

MISSOURI

STATE BOARD OF NURSING NEWSLETTER



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Governor

The Honorable Jeremiah W. (Jay) Nixon

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Address/Telephone Number

Missouri State Board of Nursing
3605 Missouri Boulevard
PO Box 656
Jefferson City, MO 65102-0656

573-751-0681 Main Line
573-751-0075 Fax

Web site: <http://pr.mo.gov>
E-mail: nursing@pr.mo.gov

Message from the President

Are You Ready to Serve?

Roxanne McDaniel, PhD, RN, President

State statute 335.021, RSMO, delineates how a board member may be appointed. You must be a citizen of the United States and a Missouri resident for at least one year. All but the public member must be a licensed nurse and actively engaged in nursing for at least 3 years immediately prior to the appointment. Membership on the board must include representatives with expertise in each level of educational programs; practical, diploma, associate degree and baccalaureate.

The make-up of the members consists of: two Licensed Practical Nurses, five Registered Nurses, one public member, and one undesignated member.

Appointments are made by the Governor with advice and consent of the Senate. The Governor may appoint a board member to fill a vacancy from a list submitted by the Missouri Nurses Association for RN members or from a list submitted by the Missouri Association of Licensed Practical Nurses for LPN members or may appoint some other qualified licensed nurse.

The Board of Nursing has had two recent resignations. Irene Coco served on the board as a LPN member from March 31, 2010 through June 7, 2013. Irene indicated that the experience she gained while working with the Board led to personal and professional growth.

Aubrey Moncrief served on the Board from April 6, 2009 through June 15, 2013. Aubrey is a self-employed CRNA. Aubrey had this to say about his experience on the Board.

"My four years (two years as president) on the Missouri State Board of Nursing can only be described as enlightening. I have learned so much about the workings of our regulatory board. The Missouri Board is run efficiently mostly due to the Executive Director Lori Scheidt and the support of the NCSBN is priceless. I only have praise for all levels of this Board. It has been an honor to have served with such talented and intelligent board members. I only hope that my brief service has been of some value and I am happy that I had a chance to give back in this way. I would highly recommend the experience and would do it all again."

My fellow board members and I would like to publicly express our sincere gratitude to both these exceptional board members for all the important work, time and dedication they contributed over the years. Irene served as secretary from 2011 to 2013 and Aubrey served as president from 2010 to 2012.

We currently have six members on our Board with three vacancies. I serve as president and am the associate dean for academic affairs at the University of Missouri Sinclair School of Nursing.

I hold a PhD in nursing and have many years as a nurse educator. Rhonda Shimmens is the vice-president of the board. Rhonda is the manager of outpatient surgery at St. Mary's Hospital. She holds a bachelor's and associate's degree as well as a MBA in health management. Lisa Green is a nurse educator. Lisa earned her master of science in nursing and has an extensive nursing practice and nurse educator career. Kelly Scott is the undesignated member. She is a Family Nurse Practitioner and works for the University of Missouri Health Care in pediatric orthopedics. Kelly holds a bachelor's and associate's degree as well as a master's in nursing. Mariea Snell is the newest member of the board. Mariea is a Family Nurse Practitioner as well as an adjunct faculty member and preceptor for a nursing program. She holds associate's and bachelor's degrees and is near completion of her doctorate in nursing practice. Adrienne Anderson Fly is the public member of the board. Adrienne is an attorney with over thirty years' experience in private practice and work for the Supreme Court Office of Chief Disciplinary Counsel.

If you think you might be interested in applying to serve on the Board of Nursing, there are two primary things you need to consider. The first is the time commitment. The board meets face-to-face five times per year. Four of those meetings are three or four days in length and one is two days in length. In addition, the board has about 40 committee conference calls per year. We spend about 20 hours per month on board work. If you accept an appointment to the Board of Nursing you have to be willing and able to devote time and effort.

The next issue is the board's mission. The mission of the Missouri State Board of Nursing is to protect the public by development and enforcement of state law governing the safe practice of nursing. The board should not be confused with a nursing association. The Missouri State Board of Nursing is a regulatory body created by statute and exists solely to enforce the laws and rules regulating nursing practice. The board's mission is to PROTECT THE PUBLIC. Nursing associations provide services to their members and represent the professionals. The mission of nursing association is to PROTECT THE PROFESSION.

Past and current board members have indicated that serving as a board member is one of the most challenging and rewarding of volunteer assignments. While appointment or election to a board is an honor, board members have important legal and fiduciary responsibilities that require a commitment of time, skill, and resources.

If you are interested in applying to be on the Board of Nursing, go to the Governor's web site at <http://boards.mo.gov/> and click on the Apply for a Board or Commission button.

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Missouri Nurses Association (MONA)	573-636-4623
Missouri League for Nursing (MLN)	573-635-5355
Missouri Hospital Association (MHA)	573-893-3700



Executive Director's Report

Authored by Lori Scheidt, Executive Director

Several bills relating to Nursing were submitted during the 2013 legislative session which has now ended. House Bill 315, Senate Bill 330 and Senate Bill 106 passed and have been signed by the Governor.

Missouri Nursing Practice Act

Senator Jay Wasson (R-District 20) filed Senate Bill 370. Passage of this bill would add additional causes for which the Board of Nursing may file a complaint and allows the Board to request an emergency suspension of a license. The language contained in this bill was added to House Bill 315 and that bill passed. This bill has been signed by the Governor and will be effective August 28, 2013.

Telehealth

Language related to telehealth was also in House Bill 315. The actual language follows.

335.175. 1. No later than January 1, 2014, there is hereby established within the state board of registration for the healing arts and the state board of nursing the "Utilization of Telehealth by Nurses." An advanced practice registered nurse (APRN) providing nursing services under a collaborative practice arrangement under section 334.104 may provide such services outside the geographic proximity requirements of section 334.104 if the collaborating physician and advanced practice registered nurse utilize telehealth in the care of the patient and if the services are provided in a rural area of need. Telehealth providers shall be required to obtain patient consent before telehealth services are initiated and ensure confidentiality of medical information.

2. As used in this section, "telehealth" means the use of medical information exchanged from one site to another via electronic communications to improve the health status of a patient, as defined in section 208.670.

3. (1) The boards shall jointly promulgate rules governing the practice of telehealth under this section.

Such rules shall address, but not be limited to, appropriate standards for the use of telehealth.

(2) Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2013, shall be invalid and void.

4. For purposes of this section, "rural area of need" means any rural area of this state which is located in a health professional shortage area as defined in section 354.650.

5. Under section 23.253 of the Missouri sunset act:

(1) The provisions of the new program authorized under this section shall automatically sunset six years after the effective date of this section unless reauthorized by an act of the general assembly; and

(2) If such program is reauthorized, the program authorized under this section shall automatically sunset twelve years after the effective date of the reauthorization of this section; and

(3) This section shall terminate on September first of the calendar year immediately following the calendar year in which the program authorized under this section is sunset.

Advanced Practice Registered Nurse Practice Bills

Senator David Sater (R-District 29) filed Senate Bill 167 and Representative Lyle Rowland (R-District 155) filed House Bill 314. Passage of either of these bills would have modified the laws relating to advanced practice

Executive Director's Report continued on page 3

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Number of Nurses Currently Licensed in the State of Missouri


As of July 23, 2013

Profession	Number
Licensed Practical Nurse	24,419
Registered Professional Nurse	94,061
Total	118,480



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registered nurses and collaborative practice arrangements.
Neither of these bills passed.

APRN Waiver of Collaborative Practice Mileage Requirement for Rural Health Clinics Only

Senator Jay Wasson (R-District 20) filed Senate Bill 330 and Representative Eric Burlison (R-District 133) filed House Bill 625. Passage of either of these would allow the geographic proximity requirement to be waived for a maximum of 28 days per calendar year for rural health clinics as long as the collaborative practice arrangement includes alternative plans for coverage. This language passed under Senate Bill 330 and has been signed by the Governor so it will be effective August 28, 2013.

Social Security Numbers on License Renewals

Senator Scott Sifton (D-District 1) filed Senate Bill 289 – and Senator Wayne Wallingford (R-District 27) filed Senate Bill 314. Passage of either of these bills would have changed the Social Security number requirement. Under current law, every application for a renewal of a professional license, certificate, registration, or permit must contain the applicant’s Social Security number. This bill stated that an application for a professional license renewal only has to include a Social Security number in situations where the original application did not contain a Social Security number. After the initial application for license renewal which includes a Social Security number, an applicant would no longer be required to provide a Social Security number in subsequent renewal applications.
Neither of these bills passed.

Military Credit

Senator Dan Brown (R-District 16) filed Senate Bill 106 and Representative Charlie Davis (R-District 162) filed House Bill 114. Passage of either of these bills would require all health-related boards within the Division of Professional Registration to establish a procedure to ensure that any member of the United States armed forces on active duty who, at the time of activation, was a

member in good standing with any professional licensing body in this state and was licensed or certified to engage in his or her profession or vocation in this state, shall be kept in good standing by the professional licensing body with which he or she is licensed or certified.

It also requires that no later than January 1, 2014, every professional licensing board or commission in this state shall, upon presentation of satisfactory evidence by an applicant for certification or licensure, accept education, training, or service completed by an individual who is a member of the United States armed forces or reserves, the national guard of any state, the military reserves of any state, or the naval militia of any state toward the qualifications to receive the license or certification.

Senate Bill 106 passed.

Malpractice Insurance Proof for Homebirth Services

Representative Caleb Jones (R-District 50) filed House Bill 308. Passage of this bill would have required that any person certified and providing homebirth services shall, prior to the provision of such services, furnish to all individuals for whom such services will be provided satisfactory evidence that such person has obtained and maintains a midwifery malpractice insurance policy with coverage of at least one million dollars. Any person who fails, prior to the provision of such services, to present proof of such malpractice insurance coverage is guilty of a class C misdemeanor.

This bill did not pass.

Board of Professional Midwives

Representative Kurt Bahr (R-District 102) filed House Bill 514. Passage of this bill would have created a “Board of Professional Midwives” within the Division of Professional Registration. This would be a six member board with five professional midwives and one public member. A professional midwife is defined as a person who is certified by the North American Registry of Midwives (NARM) as a certified professional midwife (CPM) and provides, for compensation, those skills relevant to the care of women and infants in the antepartum, intrapartum, and postpartum periods. It would give the board similar powers as other boards to

issue licenses, renew licenses, deny licenses, conduct investigations, etc.

This bill did not pass.

Influenza Vaccination Requirement

Representative Jill Schupp (D-District 088) filed House Bill 792. Passage of this bill would have required every employee and volunteer of a health care facility inspected by the department of health and senior services to receive an influenza vaccination each year.

This bill did not pass.

Governor’s Action

The Governor has 15 days to act on a bill if it is sent to him during the legislative session and 45 business days if the legislature has adjourned or has recessed for a 30-day period. The bills I mentioned in this article that passed were all delivered to the Governor after the legislative session adjourned so he has 45 days to act.

If he signs any of these mentioned bills, they will be delivered directly to the Office of the Secretary of State and will become law August 28, 2013.

If he vetoes a bill, it is returned to the house of origin with his objections. A two-thirds vote by members of both houses is required to override the Governor’s veto.

If the Governor neither vetos a bill nor signs a bill during the time period allowed, it will become law in the same manner as if the Governor signed it.

Your Role in the Legislative Process

Legislation impacts nursing careers, shapes health care policy and influences the care delivered to patients. Your education, expertise, and well-earned public respect as a nurse can allow you to exert considerable influence on health care policy. Nurses have been somewhat reluctant to do this in the past but you are in an excellent position to advocate for patients. Never underestimate the importance of what you have to say.

As a professional, you bring a unique perspective to health care issues and often have intricate knowledge that helps provide insight for our legislators.

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Education Report

Nurse Expansion Initiative – Increased Capacity for Clinical Education

Authored by Bibi Schultz, RN MSN, CNE Education Administrator

Missouri State Board of Nursing (MSBN) Education Committee Members:

- Roxanne McDaniel, RN, PhD (Chair)
- Lisa Green, RN, PhD(c)
- Mariea Snell, MSN, BSN, RN, FNP-BC

As most of you know, applications to enter nursing programs are steadily on the rise. Often nursing programs struggle to find enough qualified faculty and to secure appropriate clinical placements for larger numbers of students. The Missouri Action Coalition – Future of Nursing has adopted faculty recruitment, retention and diversification as one of the major initiatives to support and expand nursing education. The concept of life-long learning directly relates to development and expansion of nurse educator resources. Many nursing schools offer nurse educator tracks within their graduate studies that allow schools to “grow their own.” In addition, recent data indicates that through efforts of the Workforce Collaborative Pilot Project increased availability of clinical faculty has positively impacted nursing school capacity to clinically educate students.

The Workforce Collaborative Pilot Project – Nurse Expansion Initiative (Pilot Project) emerged from a series of community-wide meetings in the Kansas City area to address the nursing shortage. The great need for additional qualified faculty, especially in clinical settings, was at the forefront of discussion. The need to expand the pool of masters-prepared nurses to teach nursing students, to increase nursing school enrollments and to develop and evaluate innovative educational models that could be sustained and replicated were identified as major factors in addressing the nursing shortage/ability to educate more students, as indicated in the 2011-2012 Workforce Collaborative Pilot Project – Annual Report.

In August of 2004 Kansas City area nursing schools submitted a proposal to the Missouri State Board of Nursing (MSBN) for approval of a Pilot Project designed to expand clinical faculty resources. St. Louis metropolitan area nursing schools joined the initiative in 2005. The MSBN approved the proposal, granted a regulatory exemption to faculty approval and continues to support this Pilot Project. Through collaboration with the Missouri Hospital Association, participating nursing schools, and practice partners, the Clinical Faculty Academy program was founded. Nurse educators developed a standard curriculum for a two-day educational session (Clinical Faculty Academy) geared to prepare nurses for clinical teaching. This regulatory exemption allows BSN-

prepared nurses currently working on a graduate degree in nursing to teach as clinical adjunct faculty at the BSN program level once Clinical Faculty Academy (CFA) requirements have been met. The exemption is currently approved by the MSBN through 2014. Outside of this exemption, Minimum Standards for Professional Nursing Programs require nursing faculty teaching at the BSN level to be at minimum MSN- prepared.


Missouri Hospital Association staff and a nurse educator steering committee continue to work together to provide at least two CFA sessions in each metropolitan area of the state each year. Sessions are usually scheduled in January and August. Additional sessions are occasionally offered in the Columbia and Springfield areas to provide this opportunity to nurses in the middle of the state.

Each year the Missouri Hospital Association in collaboration with participating nursing schools and practice partners submits an Annual Report indicating current Pilot Project outcomes. Approximately 65% of CFA attendees completed 2011-2012 surveys. Additional data is obtained through collaboration with Kansas City and St. Louis nursing schools. While the need for nursing faculty is ongoing, annual reporting indicates the significant impact of the CFA to expand clinical faculty resources. The 2011-2012 Annual Report reflects that a total of 298 nurses attended CFA sessions between August 2010 and January 2012. Furthermore, in fall 2011 alone, CFA attendees provided clinical instruction for at least 534 nursing students. Similar numbers are reported for spring of 2012. Attendees rated preparation through the CFA resources very positively. Growing interest to become full-time nursing faculty is reflected. At least 37 attendees are projected to complete graduate studies in 2013.

When reviewing this data, it is important to remember that willingness of Missouri nurses to share their expertise through clinical teaching continues to impact nursing education and aids students to make the transition to professional nursing practice. As reported by the Missouri Hospital Association in 2012, a total of 1,047 nurses in the Kansas City and St. Louis areas have attended the CFA since its inception in 2004. It is essential for nurses to utilize all opportunities for professional development and to actively collaborate with their colleagues in nursing education. What better way to utilize clinical expertise than to foster nursing education, gain valuable experience as clinical adjunct faculty and complete graduate studies while working side-by-side with experienced nurse educators. For additional information about the CFA please contact LeAnn Jackson or Jean Klindt at the Missouri Hospital Association at 573-893-3700.

Reference:

2011-2012 Annual Report of the Workforce Collaborative Pilot Project – Regional Offices of the Kansas and Missouri Hospital Associations



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2013 Golden Awards

We are happy to announce that Golden Certificates were recently sent to 238 Registered Nurses and 42 Licensed Practical Nurses. These individuals have active licenses and have been licensed in the State of Missouri for 50 years. We take great pleasure in marking this special achievement in the eighth year of our Golden Award Recognition program. Two of this year’s honorees served as members of the Board of Nursing: Karen S Hendrickson (1992-1997) and Cheryl Primm (1990-1993). A list of those receiving Golden Certificates follows.

LPN	Martha S. Kowalczyk	Bridgeton, MO	RN	Jane B. Ollendorff	University City, MO	RN	Helen R. Bertolino	Maryland Heights, MO
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LPN	Ruby L. Reeder	St. Louis, MO	RN	Martha S. Bartelsmeyer	Mount Vernon, MO	RN	Judith A. Nicolson	Kirkwood, MO
LPN	Pearlie W. Savoy	St. Louis, MO	RN	Georgia C. Chittim	Springfield, MO	RN	Nancy V. Cook	Ballwin, MO
LPN	Priscilla S. Faulkner	Holt, MO	RN	Judith A. Flacke	Manchester, MO	RN	Betty B. Gordon	Aurora, MO
LPN	Paula A. Thomas	Kansas City, MO	RN	Donna L. Fotopoulos	Olathe, KS	RN	Carol A. McBee	Seymour, IN
LPN	Carolyn J. Clair	Conway, MO	RN	Jeane C. Wagner	Forsyth, MO	RN	Verda J. Hyland	Smithville, MO
LPN	Edith F. Hites	Golden City, MO	RN	Delma J. Killingsworth	Springfield, MO	RN	Helen M. Lee	Greenwood, MO
LPN	Betty R. Sweikar	Ozark, MO	RN	Beverly C. Hardy	Willard, MO	RN	Martha S. Nemnich	Florissant, MO
LPN	Ruth E. Durrett	St. James, MO	RN	Ella E. Hill	McClure, IL	RN	Laura A. Hamtil Klages	St. Louis, MO
LPN	Nancy N. Hembrey	Parkville, MO	RN	Doris K. Surbrugg	Joplin, MO	RN	Sandra L. Blaesing	Kansas City, MO
LPN	M. Deloris Russell	Golden City, MO	RN	Elizabeth J. Pettit	Neosho, MO	RN	Mary Beth Oreilly	Nixa, MO
LPN	Sallie M. Johnson	St. Louis, MO	RN	Betty C. Morris	Conway, MO	RN	Judith A. Meiser	St. Charles, MO
LPN	Tessie Louise Ward Leverette	Florissant, MO	RN	Virginia F. Ross	Springfield, MO	RN	Elizabeth A. Beussink	Leopold, MO
LPN	Patricia E. Williams	Fordland, MO	RN	Warren S. Daniel	Kansas City, MO	RN	Mary T. Cochran	St. Louis, MO
LPN	Rosella L. Lee	St. Peters, MO	RN	Barbara J. Sabol	Lawrence, KS	RN	Kathleen Zimmerman	Centerville, MO
LPN	Patricia A. Dishman	Warrenton, MO	RN	Patricia Agnes Wyatt	Lee’s Summit, MO	RN	Nancy E. Morgan	St. Louis, MO
LPN	Brenda M. Newkirk	O’Fallon, MO	RN	Mary J. Reist	Kansas City, MO	RN	Sharon K. Barton	St. Peters, MO
LPN	Wanda L. Maupin	Kansas City, MO	RN	Judith H. Bumpas	Blue Springs, MO	RN	Susan M. Maravich	Manchester, MO
LPN	Ladon K. Pfeifer	St. Charles, MO	RN	Martha E. Anderson	Blue Springs, MO	RN	Ruth A. Gerhardt	St. Louis, MO
LPN	Ava P. Sellenriek	O’Fallon, MO	RN	Sandra R. Carter	Kansas City, MO	RN	Sandra M. Greiwe	St. Charles, MO
LPN	Joyce B. Beasley	Kansas City, MO	RN	Patricia K. Barsotti	Aurora, MO	RN	Connie H. Harashe	St. Louis, MO
LPN	Helen N. Hoffman	Bevier, MO	RN	Marjorie C. Gorham	Joplin, MO	RN	Janet L. Fisher	Chesterfield, MO
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LPN	Betty V. Bopp	Cuba, MO	RN	Jane E. Spencer	Augusta, MO	RN	Barbara J. Dowell	Mexico, MO
LPN	Judy S. Frakes	Kennett, MO	RN	JoAnn F. Rose	Wheatland, MO	RN	Mary F. Brinson	Savannah, MO
LPN	Lutheria E. Sells	Kansas City, MO	RN	Marcia R. Jones	Shell Knob, MO	RN	Janice E. Holtzclaw	Agency, MO
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LPN	Deloris S. Drown	Salisbury, MO	RN	Barbara W. Haubold	Bertrand,MO	RN	Joan H. Harper	Chesterfield, MO
LPN	LaVerne Dednam	St. Louis, MO	RN	Ruby J. Majors	Imperial, MO	RN	Margaret A. Brooks	Auxvasse, MO
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Practice Corner

Authored by **Debra Funk, RN**
Practice Administrator

The Board office receives several newsletters from other boards of nursing across the country. As I was reading the Arkansas State Board of Nursing Spring 2013 "Update", I came across an article that the president of their Board had written on professionalism and wanted to share it with our Missouri nurses.

Professionalism
Karen Holcomb, RN
President, Arkansas State Board of Nursing
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Arkansas State Board of Nursing

In order to understand the concept of professionalism in nursing, we first need to define the word profession. Webster describes profession as a "chosen, paid occupation requiring prolonged training and formal qualifications."¹ Professionals can be defined as individuals expected to display competent and skillful behaviors in alignment with their profession. Being professional is the act of behaving in a manner defined and expected by the chosen profession. This framework for professionalism in nursing began during our early roots with Florence Nightingale who set the bar rather high in regard to giving herself to others and her expectation of excellence in nursing practice. She was an inventor, a visionary and a missionary. She delivered nursing care to all with a commitment to passion and love. We, as nurses, are no different. We bear the tremendous responsibility of

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upholding the values of our profession. Our core nursing values define the driving force that dictates our beliefs and our behaviors. "Nursing values include honesty, responsibility, pursuit of new knowledge, belief in human dignity, equality of all patients and the desire to prevent and alleviate suffering."² Your professionalism will be judged in your personal behaviors and how you present yourself to all those around you, and through those behaviors, you tell the world who you are. Your professionalism includes your attitude, your appearance and your willingness to help others.

I am sure you all can identify people in your work environment with a terrible attitude who do their best to make the rest of the staff miserable. I have seen this many times, and they are creating a miserable work environment. People behave like this because they are looking for attention, and by doing so, everyone else around them is caught up this person's drama. This type of behavior is not to be accepted in the nursing profession. People need to understand that personal issues need to be left at home and not brought in to the work environment. There are always going to be times when we face issues in our lives that bring us down. I find it helpful to be grateful for everything I have. By being grateful for what we have, our whole outlook on life changes, and the way we relate to people becomes more meaningful. Be grateful because you "get to" be a nurse; you get to pick up your kids from school. Be grateful you get to spend another day with your parents and/or other family members.

People judge you by your personal appearance. Clean scrubs, well groomed hair, etc., make the statement that you care about yourself as a person and have the capacity to care about others. As a licensed nurse, your responsibility is to promote health and well-being. A nurse who is off duty must remain professional. A nurse charged with driving under the influence of alcohol would not be well accepted. Under the Nurse Practice Act for our state, you will find a section that deals with disciplinary measures. Here, you will most likely find that not only will you be punished by the laws of our state for the DWI, but your nursing license is subject to disciplinary action. This is true even though you were not on duty at the time of DWI. The commission of other criminal acts, not limited to malpractice issues or the illegal use of drugs, can also result in disciplinary action of your nursing license. These can include things such as writing bad checks, shoplifting, fraud, etc. Remember, you are a professional person and you are expected to conduct yourself in a professional manner at all times. Nursing is the most trusted profession in the world. Show the world how wonderful we are by always putting your best foot forward not only for yourself, but for all of us in this wonderful profession!

- References:**
- 1 www.meriam-webster.com
 - 2 www.nursetogether.com/Career/Career-Article/itemId/2245

Note: Please remember that this article was written for the nurses in Arkansas. The Missouri Nurse Practice is not exactly the same as the Arkansas Nurse Practice Act but the causes for discipline in Missouri are very similar.

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Avoiding Violations of Patient Privacy With Social Media

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Tatiana Melnik, JD

Social media allows the instantaneous dissemination of information to a large audience. Thus, social media provides a means for distributing vital health care information – and an easy means of violating patient privacy. This article provides a summary of social media and privacy laws, discusses the legal issues health care organizations and workers face when a breach of patient privacy occurs, and offers best practices for avoiding privacy violations.



Learning Objectives

- Discuss state and federal law related to patient privacy.
- Describe examples of inappropriate use of social media.
- Identify strategies for reducing the risk of using social media.

Health care has felt the impact of social media, including the effect of its improper use. News reports have highlighted improper behaviors by health care workers, ranging from posting photographs of patients' X-rays to improperly sharing excerpts from medical records. Such breaches violate patient privacy, which in turn damages the reputation of the health care system. Individual nurses responsible for these improper behaviors also pay a higher price if their actions are reported to the state board of nursing (BON).

This article provides an overview of social media and privacy laws, examines the legal issues nurses will encounter after violating patient privacy via social media, and provides some recommended practices.

Uses of Social Media in Health Care

At its most basic level, social media is a tool for communicating. By using social media, people can disseminate information and communicate instantaneously to a large audience. The Mayo Clinic, for example, permits attendance at its continuing education symposiums through Second Life, a virtual world where people are represented by avatars (Mayo Clinic, 2012). Those who attend through the virtual community see the same presentations and videos and receive the same number of continuing education credits as those attending live. After the earthquake and tsunami in Japan in 2011, physicians used Twitter to advise chronically ill patients on where to go to pick up medication (Tamura & Fukuda, 2011). Using Twitter was helpful because its retweet feature "facilitate[d] rapid sharing of other participants' messages with all of one's followers, resulting in an exponential proliferation of information dispersal" (Tamura & Fukuda, 2011). The physicians found that Twitter was a good option because while the telephone networks were down, Internet connections remained stable.

Social media also provides a collaborative environment in which anyone can make a difference. In February 2009, for example, Dr. Bertalan Meskó, then a medical student at the University of Debrecen in Hungary, tweeted a request for assistance with a strange case: A 16-year-old boy had what appeared to be acute pancreatitis for the sixth time (Miller, 2010; Park, 2012). Dr. Meskó received responses from physicians all over the world, and one of the suggestions – microlithiasis, a rare disorder – was correct.

The current social media tools require little expertise to use because they are primarily point-and-click. Twitter accounts, for example, can be set up in less than 5 minutes, and at only 140 characters, a tweet can be keyed and sent in seconds. A large number of social media websites for the general user, including Facebook, Twitter, YouTube, LinkedIn, and Pinterest, are available. Many websites are tailored to the health care industry:

- Medscape (www.medscape.com), part of WebMD and the WebMD Health Professional Network, is tailored to medical professionals, offering integrated medical information and educational tools.
- Nurse Together (www.nursetogether.com) is a social networking website for nurses, featuring forums,

videos, continuing education courses, expert advice, and job resources.

- Sermo (www.sermo.com) is a social networking website claiming a membership of over 125,000 U.S. physicians.
- Patients Like Me (www.patientslikeme.com) permits people with certain illnesses to find others with similar illnesses and track (and share publicly) information on their conditions, including drugs they are taking and test results. The web site claims a membership of more than 162,000 patients and coverage of more than 1,000 conditions.
- Daily Strength (www.dailystrength.org) features support groups and discussion boards and permits members to keep a wellness journal. The site is open to caregivers, supporters, and medical professionals as well as patients.

Additionally, social media is a low-cost method of communication. The Mayo Clinic reportedly spent less than \$1,500 to implement its social media tools (Morrison, 2009).

Federal and State Laws Protecting Patient Privacy

The privacy of patient health care information is protected by federal and state law. Federal laws set the foundation for protection, and state laws generally strengthen the foundation. The practice of nursing is regulated by state law, but because nurses are handling protected health information, they are subject to compliance with both federal and state law.

Federal Law

The primary federal source of protection is the Health Insurance Portability and Accountability Act of 1996 (HIPAA; U. S. Department of Health and Human Services [HHS], 2009). Congress passed HIPAA because it recognized that, as health care providers incorporated more technology into their practices, patient data would become more susceptible to improper disclosure (H. R. Rep. 104-496 Part 1, 1996). Through HIPAA, Congress directed the Secretary of Health and Human Services (HHS) to adopt privacy and security standards aimed at protecting health information (Health Insurance Portability And Accountability Act, 1996). These standards are called the Privacy Rule and the Security Rule and are administered and enforced by the HHS Office of Civil Rights (OCR; HHS, n.d.).

The second federal law that protects health information is the Health Information Technology for Economic and Clinical Health (HITECH) Act, which was passed as part of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5, 123 Stat. 115, 2009). The HITECH Act sets forth stronger privacy and security protections for patient data through mandatory breach notification requirements, a tiered civil penalty structure, and the right of state attorneys general to enforce HIPAA on behalf of their citizens. Under the HITECH Act, HHS issued the Breach Notification Rule, which is enforced by the OCR (HHS, 2009, August). As such, the HITECH Act increases financial liabilities for non-HIPAA-compliant health care organizations.

HIPAA, the HITECH Act, and their implementing rules, collectively referred to in this article as HIPAA, focus on protecting people's medical records and other health information, content that is generally called protected health information (PHI). HIPAA applies to covered entities (CEs) and their business associates, which are entities that perform certain functions on behalf of CEs (Federal Code of Regulations, 2012). CEs include health plans, health care clearinghouses, and health care providers who transmit health information in electronic form in connection with a transaction (Federal Code of Regulations, 2012). In general, nurses fall within the definition of CEs because they are health care providers and their practice or hospital transmits PHI electronically.

State Law

States have passed numerous laws protecting health care information. The laws vary from state to state and focus on different issues, such as setting forth a patient bill of rights (Illinois Medical Patient Rights Act, n.d.; Minnesota Office of the Revisor of Statutes, 2012) and setting forth certain disclosure and protection requirements for mental health information (Iowa Code, n.d.; Michigan Mental Health Code, 1974) and sexually transmitted disease records (Iowa Code, 2011).

State laws may overlap with provisions of HIPAA, such as requiring that health care providers offer patients access to their medical records (Michigan Medical Records Access Act, 2004). Forty-six states have also passed data breach notification laws (National Conference of State Legislatures, 2012), and health care providers involved in a breach must comply with the HITECH Act as well as any applicable state law. Pursuant to the HITECH Act, health care organizations whose breach affects 500 or more individuals are listed online (HHS, 2012). As of this writing, 504 reports have been posted, with some organizations listed more than once (HHS, 2012). Similar to the HITECH Act, state laws require health care organizations that experience a breach to notify the affected individuals and, under some circumstances, to notify the media and the state's attorney general.

Nursing Regulation

Nursing practice is regulated by state law, which delegates power to a BON. The BONs establish licensing criteria and the licensing process, define and enforce the scope of practice, investigate complaints, and impose discipline. BONs generally have broad authority to regulate the nursing profession because they have a duty to keep the public safe and maintain the integrity of the profession as well as the health care system as a whole.

Though nursing laws differ from state to state, common forms of social media misuse and abuse generally fall under more general grounds for discipline. These grounds include general laws governing unethical conduct that discloses PHI or is "likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient" (Minnesota Office of the Revisor of Statutes, 2012) and violating community standards or "rules and standards of conduct and practice as may be adopted by the board" (Idaho Code, 2012).

The nursing profession is particularly impacted by the HITECH Act because of its data breach notification requirements. The HITECH Act defines a breach as "the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information, *except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information*" (U. S. Code, 2010a). Disclosing information online is an automatic breach under the HITECH Act because once something is posted online, it is retained. (There are several other exceptions under the HITECH Act; however, none of them are applicable to PHI that has been posted online).

The breach of disclosing information online triggers the HITECH Act's notice obligation, which requires that CEs provide notification to the impacted individual "without unreasonable delay" and no longer than 60 days after a breach is "discovered" (U. S. Code, 2010b). A breach is discovered when it is known, or by exercise of reasonable diligence, would have been known by a member of the CE's workforce (HHS, 2009; U. S. Code, 2010c).

HHS clarified in the Interim Final Rule that, "covered entities should ensure their workforce members and other agents are adequately trained and aware of the importance of timely reporting of privacy and security incidents and of the consequences of failing to do so" (HHS, 2009). Practically, this means that a worker who learns that a coworker improperly disclosed PHI must report the incident to the employer's privacy officer. Because of the penalties imposed by the HITECH Act and the actions taken by OCR, many employers terminate the employment of employees who commit a HIPAA breach and employees who fail to report a breach in accordance with the employer's requirements.

Legal Consequences

The last few years have seen several high profile legal cases of health care workers violating patients' privacy rights using social media tools, though none of these cases have involved nurses. Health care workers, including nurses, who violate federal and state health care privacy laws may be subject to criminal penalties and civil sanctions, may lose their licenses, and may be terminated by their employers.

The HIPAA statute provides the Department of Justice with the authority to prosecute persons for HIPAA violations (U. S. Code, 2010d). The most severe violations are subject to a fine of up to \$250,000 and up to 10 years

Continuing Education continued from page 7

in federal prison. The OCR reviews consumer complaints and refers those involving potential criminal violations to the Federal Bureau of Investigation for investigation (Department of Justice, 2011a). The matter is then referred to the Department of Justice as appropriate. Individuals are often prosecuted when medical records are stolen to commit health care fraud, embarrass people, or extort a business entity (Department of Justice, 2011b). As a federal court made clear in a decision in May 2012, one can be prosecuted under HIPAA without knowing that obtaining PHI is illegal. A person only needs to know that he or she “obtained individually identifiable health information relating to an individual” without authorization (U. S. v. *Zhou*, 2012).

[T]here are two elements of a Section 1320d-6(a) (2) violation: 1) knowingly obtaining individually identifiable health information relating to an individual; and 2) obtaining that information in violation of Title 42 United States Code Chapter 7, Subchapter XI, Part C. Thus, the term ‘knowingly’ applies only to the act of obtaining the health information and not having the knowledge that obtaining the information was illegal. (U. S. v. *Zhou*, 2012)

In U. S. v. *Zhou*, a research assistant in rheumatology accessed the health records of celebrities without authorization in 2003. He was officially charged in 2008, and the appellate court issued its decision in May 2012, almost 10 years after the employee committed the breach.

Health care workers may also be charged with violating state privacy laws. In March 2012, for example, an Oregon nursing assistant was convicted by a jury of misdemeanor invasion of privacy after she took photographs of patients in compromising positions and posted them on Facebook with unflattering commentary (Iwanaga, 2012). The conviction resulted in 8 days in jail, 2 years of probation, an order to write a 1,000-word letter of apology, a fine of \$500, and the surrender of the nursing assistant’s certification.

Similarly, in July 2011, an Indiana certified nursing assistant (CNA) was charged with voyeurism after she posted a picture on her Facebook account of a paraplegic patient’s buttocks after he soiled the bed (CNA put nasty photo, 2011). Her coworker saw the photograph on Facebook and, in accordance with HITECH requirements, reported the breach. The Indiana Attorney General’s Office eventually dropped the voyeurism charges; nonetheless, the CNA’s employment was terminated, and her CNA certification was revoked (Personal communication, 2012).

Employers have generally taken a hard line against those who violate patients’ privacy rights on social media websites, choosing to terminate the offenders immediately.

In large part, this stance results from the negative repercussions institutions experience as a result of privacy breaches, including negative publicity and a decline in employee morale. Most significantly, these breaches lead to a loss of patient trust and the inevitable report to the OCR.

In July 2011, the OCR entered into a resolution agreement with the University of California at Los Angeles Health System (UCLAHS) in which the UCLAHS agreed to settle potential violations for \$865,500 and accept a 3-year corrective action plan (HHS, 2011a). The OCR’s investigation was prompted by two patients who complained that their medical records were viewed without a permissible reason (HHS, 2011b). During its investigation, the OCR found numerous instances of employees improperly accessing patient medical records over a period of several years (HHS, 2011b). The OCR also found that the UCLAHS was aware of the activities and “failed to apply appropriate sanctions and/or document sanctions on workforce members” (HHS, 2011c; See Table 1). Although these breaches did not involve the use of social media technologies, the OCR made clear that it will hold CEs accountable for the misbehavior of their employees and that it expects CEs to sanction their employees appropriately.

<p>Table 1</p> <p>OCRs’ Ruling on Employer Responsibility</p> <p>During an investigation, the Office of Civil Rights (OCR) found that employees of the University of California at Los Angeles Health System (UCLAHS) improperly accessed patient medical records and that the UCLAHS was aware of the activities and failed to take action. In response, the OCR stated:</p> <p>Covered entities are responsible for the actions of their employees. This is why it is vital that trainings and meaningful policies and procedures, including audit trails, become part of the everyday operations of any health care provider . . . employees must clearly understand that casual review for personal interest of patients’ protected health information is unacceptable and against the law . . . Covered entities need to realize that HIPAA privacy protections are real and OCR vigorously enforces those protections. Entities will be held accountable for employees who access protected health information to satisfy their own personal curiosity . . . (U. S. Department of Health and Human Services, 2011)</p>

Recommendations for Best Practices

Recommended best practices for nurses using social media include the following:

- **Remember your role in the community.** Nurses, like all health care professionals, are held to a higher standard. Nurses occupy a particularly important role because they are often the ones who hold a patient’s hand and soothe a patient through a particularly tough treatment. Patients often trust nurses simply because they hold the title of nurse. Thus, it is easy to understand how violations of privacy would be damaging to both the patient and the nursing profession. Nurses must remember that their actions not only affect them, but also their colleagues. Certainly, the fine at the UCLAHS was felt by all employees, even though only a few engaged in the unlawful activity.
- **Think twice before you submit.** Once information is released online, retrieving it is almost impossible. Moreover, PHI posted on Facebook or Twitter is a reportable breach under the HITECH Act. Nurses should err on the side of caution when a particular Facebook status update or Tweet involves or references a patient. When in doubt, *do not* hit submit.
- **Be wary because PHI may not be obvious.** The examples in this article are blatant HIPAA violations, but not all violations are so obvious. In 2009, an administrative assistant at the nursing school of University Medical Center (UMC) “was strongly encouraged to resign” after she responded to a Tweet sent by then Governor Haley Barbour (Straw, 2009).

Consider the exchange:

Governor: “*Glad the Legislature recognizes our dire fiscal situation. Look forward to hearing their ideas on how to trim expenses.*”

Employee: “*Schedule regular medical exams like everyone else instead of paying UMC employees overtime to do it when clinics are usually closed.*” (Straw, 2009)

The employee believed she was exercising her right to freedom of speech. But her comment was problematic because she disclosed that the governor was a patient of UMC. As an administrative assistant, this employee was subject to HIPAA because the medical center is responsible for the actions of the workforce.

Workforce means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity.

A covered entity is liable, in accordance with the federal common law of agency, for a civil money penalty for a violation based on the act or omission of any agent of the covered entity, including a workforce member, acting within the scope of the agency. (Federal Code of Regulations, 2011, 2012).

The best practice is to avoid *any* discussion or comment on patient information without express authorization.

- **Follow professional standards and organizational guidelines.** In 2011, the National Council of State Boards of Nursing published *White Paper: A Nurse’s Guide to the Use of Social Media* (National Council of State Boards of Nursing, 2011) and the American Nurses Association published *ANA’s Principles for Social Networking and the Nurse* (American Nurses Association, 2011). Following these guidelines will help you minimize your risk of inappropriately using social media (Cronquist & Spector, 2011).
- **Remember the golden rule and do the right thing.** Navigating the legal framework surrounding PHI can be challenging. Remembering the golden rule – treat others as you would have them treat you – may help. Nurses should place themselves in the shoes of their patients and consider whether they would find the particular activity acceptable if the roles were reversed.

Additionally, nurses who see other health care professionals violating HIPAA must report the violations to the privacy officer as quickly as possible to ensure that the CE can meet HITECH Act reporting obligations. A nurse who remains quiet risks his or her own job and helps someone else get away with violating federal law. Also, if the OCR issues a civil penalty, keeping quiet may jeopardize the jobs of colleagues and friends.

Conclusion

By understanding the pertinent legal issues and the potential pitfalls of using social media, nurses can protect their patients’ safety and privacy and retain nursing’s position as the most trusted profession.

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At the time this article was written, **Tatiana Melnik, JD**, was an Associate Attorney at Dickinson Wright PLLC in Ann Arbor, Michigan.

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Avoiding Violations of Patient Privacy with Social Media
Learning Objectives

- Discuss state and federal laws related to patient privacy.
- Describe examples of inappropriate use of social media.
- Identify strategies for reducing the risk of using social media.

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Posttest passing score is 75%.
Expiration: January 2016

Posttest
Please circle the correct answer.

1. Which of the following is a drawback of social media?
a. Information posted online is retained forever.
b. Signing up for and using social media require little expertise.
c. Social media provide a collaborative environment.
d. Social media allow access to information for all users.
2. Which social media platform is ideal for continuing education symposiums?
a. LinkedIn
b. SecondLife
c. YouTube
d. Facebook
3. The Health Insurance Portability and Accountability Act (HIPAA) applies to covered entities. Which of the following is NOT a covered entity?
a. Health plans
b. Patients
c. Nurses
d. Healthcare clearinghouses
4. Which of the following administers and enforces the privacy rule and the security rule?
a. Social Security Administration
b. Centers for Medicare & Medicaid Services
c. Office of Civil Rights
d. Bureau of Justice Statistics
5. What is one of the purposes of the Breach Notification Rule?
a. To protect nurses from civil action when a data breach occurs
b. To ensure all states pass data breach notification laws
c. To require HIPAA covered entities to notify individuals when unsecured protected health information is disclosed.
d. To require HIPAA covered entities to notify a state’s attorney general when a breach occurs
6. Which of the following examples is an inappropriate use of social media?
a. Posting photographs of patients on Facebook.
b. Using Twitter to advise chronically ill patients where to go to pick up medications after a disaster
c. Requesting medical assistance for an unusual case using Twitter
d. Posting personal information and accomplishments on LinkedIn
7. Which statement about the relationship between state and federal patient privacy laws is correct?
a. State laws supersede federal laws in the courts.
b. Federal laws always preempt state laws.
c. State laws are uniform in design and scope.
d. State laws may overlap with federal laws.
8. Which of the following statements about a HIPAA violation is true?
a. The statute of limitations to file a lawsuit for a HIPAA violation is 6 years.
b. A health care worker may use the defense of not knowing that obtaining personal health information is illegal.
c. A health care worker may have to serve up to 10 years in federal prison.
d. HIPAA may not apply if the privacy of a celebrity is involved.
9. The Health Information Technology for Economic and Clinical Health (HITECH) Act is a part of which federal law?
a. Civil Rights Act
b. American Recovery and Reinvestment Act
c. Omnibus Reconciliation Act
d. Consolidated Omnibus Budget Reconciliation Act
10. When was HIPAA enacted?
a. 1996 b. 2001 c. 2005 d. 2009
11. What is the primary duty of a board of nursing?
a. To write laws to regulate nursing
b. To discipline nurses

- c. To protect the nursing profession
d. To keep the public safe
12. A staff nurse learns that a coworker improperly disclosed private health information about a patient. What should the staff nurse do next?
a. Urge the coworker to submit written testimony about the incident.
b. Report the incident to the employer’s privacy officer.
c. Report the incident to the state’s attorney general.
d. Refer the coworker to a local attorney specializing in civil law.
13. A health care organization discovers that unauthorized protected health information has been posted online. What must the organization do?
a. Contact the state board of nursing within 30 days after the breach is discovered.
b. Fire all health care workers who are involved in or have knowledge of the incident.
c. Notify the affected individual within 60 days of the discovery of the breach.
d. Post an online apology about the breach within 30 days of the discovery of the breach.
14. What is the most compelling reason for a nurse to protect patient privacy?
a. The nurse could be fired if caught disclosing patient information.
b. The nurse could lose his or her license if caught disclosing patient information.
c. Patients can sue the nurse for disclosing patient information.
d. Patients trust nurses and hold them to a higher ethical standard.
15. A nurse is presenting information during an inservice meeting about social media. Which of the following should the nurse reinforce?
a. Follow professional standards and organizational guidelines.
b. Do not use social media.
c. Restrict Facebook account permissions to colleagues.
d. Do not identify yourself as a nurse when posting information online.

Evaluation Form (required)

1. Rate your achievement of each objective from 5 (high/excellent) to 1 (low/poor).

- Discuss state and federal laws related to patient privacy.
1 2 3 4 5
- Describe examples of inappropriate use of social media.
1 2 3 4 5
- Identify strategies for reducing the risk of using social media.
1 2 3 4 5

2. Rate each of the following items from 5 (very effective) to 1 (ineffective):

- Was the author knowledgeable about the subject?
1 2 3 4 5

- Were the methods of presentation (text, tables, figures, etc.) effective?
1 2 3 4 5
- Was the content relevant to the objectives?
1 2 3 4 5
- Was the article useful to you in your work?
1 2 3 4 5
- Was there enough time allotted for this activity?
1 2 3 4 5

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Message to Our Nation's Health Care Providers: HIPPA Privacy Rule

Leon Rodriguez, Director of the Office for Civil Rights of the Department of Health and Human Services

Reprinted with Permission ASBN Update April 2013 Vol 17 Number 2 Arkansas State Board of Nursing

In light of recent and horrific events in our nation, including the mass shootings in Newtown, CT and Aurora, CO, I wanted to take this opportunity to ensure that you are aware that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule does not prevent your ability to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when you believe the patient presents a serious danger to himself or other people.

The HIPAA Privacy Rule protects the privacy of patient's health information but is balanced to ensure that appropriate uses and disclosures of the information still may be made when necessary to treat a patient, to protect the nation's public health, and for other critical purposes, such as when a provider seeks to warn or report that persons may be at risk of harm because of a patient. When a health care provider believes in good faith that such a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those persons whom the provider believes are reasonably able to prevent or lessen the threat. Further, the provider is presumed to have had a good faith belief when his or her belief is based upon the provider's actual knowledge (i.e., based on the provider's own interaction with the patient) or in reliance on a credible representation by a person with apparent knowledge or authority (i.e., based on a credible report from a family member of the patient or other person). These provisions may be found in the Privacy Rule at 46 CFR §164.512(j).

Under these provisions, a health care provider may disclose patient information, including information from mental health records, if necessary, to law enforcement, family members of the patient, or any persons who may reasonably be able to prevent or lessen risk of harm. For example, if a mental health professional has a patient who has made a credible threat to inflict serious and imminent bodily harm on one or more persons, HIPAA permits the mental health professional to alert the police, a parent or other family member, school administrators, or campus police, and others who may be able to intervene to avert harm from the threat.

In addition to professional ethical standards, most states have laws and/or court decisions which address, and in many instances require, disclosure of patient information to prevent or lessen the risk of harm. Providers should consult the laws applicable to their profession in the states where they practice, as well as 42 CFR Part 2 under federal law (governing the disclosure of substance abuse treatment records) to understand their duties and authority in situations where they have information indicating a threat to public safety.

We at the Office for Civil Rights understand that health care providers may at times have information about a patient that indicates a serious and imminent threat to health or safety. At those times, providers play an important role in protecting the safety of their patients and the broader community. I hope this letter is helpful in making clear that the HIPAA Privacy Rule does not prevent providers from sharing this information to fulfill their legal and ethical duties to warn or as otherwise necessary to prevent or lessen the risk of harm, consistent with applicable law and ethical standards.



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Copy and Paste: Is it a Hazard to Your Patient's Health?

**Kim McKinley, DNP, Informatics Nursing Specialist-BC, RN
Senior Director Clinical Informatics
University Hospitals
Nurse Practice Advisory Committee Member**

Reprinted with permission Nursing News & Views, Spring 2013 Vol 8 No. 2, New Mexico Board of Nursing

Nurses, like their provider counterparts, are tasked with increasing documentation requirements and demands on the time available for patient care. Much of this is being driven by the need to comply with the ever-increasing requirements by regulatory or billing agencies and their need for electronic medical records (EMRs). In an effort to accommodate this increased need for documentation, nurses have found that they can electronically 'copy and paste' from one area of the chart to another.

While this is a time saver, it also poses a hazard. If the incorrect information is copied into the record, the patient can have unnecessary treatments or an incorrect diagnosis.

According to Thornton (2013), EMRs are designed to improve the accessibility and completeness of documentation while decreasing medical errors by transforming written scribbles into legible and standardized documents. The intent of the 2009 Health Information Technology and Economic and Clinical Act (HITECH) passed by Congress was to encourage healthcare to adopt an electronic medical record that would improve overall medical care. The HITECH Act incentivizes hospitals and providers to adopt electronic medical records and will also penalize those facilities who do not convert to an EMR by 2015.

Electronic medical record developers have sought to improve the ease of use by including the copy and paste feature. EMRs have two distinct copy and paste features. The first is a 'pull forward' function. This is where one set of data, like restraint documentation, can be pulled from one area of the chart to another. In other words, restraint documentation that needs to occur every two hours could be documented the first time and then 'pulled forward' for the subsequent evaluations.

The second is similar to that found in most word processing programs. It allows the author to highlight a section of a document, copy an area and then paste it into another area or even a different document. Nurses can use this ability to copy their narrative note from one day to the next or even one patient to another. They can also copy another nurse's note and paste it into the chart as if they wrote it themselves.

Copy and paste has been shown to decrease the work of documentation and proven particularly useful for repetitive documentation. Therein lays the hazard. Has the nurse validated that the information is correct and complete? What if they did not re-assess the patient or review the new findings? If they copied the clinical note from another nurse, are they sure that the information is correct? What happens if information entered into the chart is on the wrong patient and is then copied from one note to another without validation?

An erroneous entry into the electronic health record can have far-reaching consequences for the patient and may lead to unwarranted diagnostic tests and treatments (Gaffey, 2009). This is termed "e-iatrogenesis" or harm that resulted from health information technology (Weiner, Kfuri, Chan, et al).

The scope of this problem is huge. Thornton's team used a plagiarism-detection software to review 2,068 progress notes in an academic medical center intensive care unit. They found that 82% of the residents' notes and 74% of the attending notes were copied and pasted from elsewhere in the record. While this study does not reflect nursing practice, it does demonstrate the scope of the problem.

There are no legal standards for medical record content and it is not clear whether or not copying notes from another nurse equates to malpractice (Thielke, Hammond & Helbig, 2006). That said, copying and pasting does denigrate documentation, critical thinking and communication between the healthcare team. There have been several suggestions that one solution would be to disable the copy function in the EMR. Another would be to somehow denote that the material was copied from another source.

Demick (2008) writes in The American Health Information Management Association (AHIMA) journal that the copy and paste function is becoming more prominent and that even if EMR vendors could turn off the feature that they would not do so because customers see it as a positive aspect of an otherwise complex documentation process.

The hazard of copy and paste is that using it carries a significant amount of legal and ethical risk. Nurses are responsible for the validation of the data and acting appropriately on that data in any note that they author. They have responsibility for their documentation regardless of where that documentation originated. Used properly, copy and paste can be a timesaving adjunct. Used improperly, it can be a hazard.

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Understanding Unethical Behavior

New Mexico Board of Nursing
Tani C. Skinner, MSN, RN

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Introduction

To understand unethical behavior, one must first understand what constitutes ethics and ethical behavior. Ethics comes from the ancient Greek word meaning character or customs. These customs or values are the determination of what is right and wrong within a society (Bosek, 2001). Based on these values, ethics relates to the process of determining the best course of action when faced with conflicting choices (Rushton, 2001).

Ethical behavior respects the dignity, diversity and rights of individuals and groups of people. Unethical behavior is concerned with ethical behavioral conflicts in the process of identifying, analyzing, and resolving moral and value issues in patient care (La Puma, 1990). While ethical behavior has been demonstrated to provide benefit to both patients and staff, unethical behavior may cause significant harm (McNaughton, et al, 2006). An ethical dilemma arises when an individual is required to make a choice between two equally unfavorable alternatives (Catalano, 1994).

The four major principles of healthcare ethics include: respect for autonomy; non-maleficence; beneficence; and justice. Though not considered to be absolute, these rules and principles serve as persuasive guides for action (McCormick, 1998). These four principles are contained in the Nursing Code of Ethics and form the basis for ethical decision making in nursing practice (Catalano, 1994).

Examples of unethical behavior can be seen in clinical practice, education, research, and administration. Shortages in the number of healthcare providers to deliver patient care, inadequate staffing patterns, cost containment measures, and ineffective leadership have resulted in the escalation of ethical dilemmas nurses face today in healthcare environments (Clancy, 2003; Einarsen, Aasland & Skogstad, 2007; Murray, 2008; Zangaro, et.al. 2009). How individuals react and ultimately respond to these ethical dilemmas is dependent upon their previous experiences with unethical behavior, their individual personality traits, and their ethical values, as well as their knowledge of ethical principles (Clancy, 2003).

Because of the complexities of modern-day living and the heightened awareness of an educated public, ethical issues related to health care have surfaced as a major concern of both healthcare providers and recipients of these services (Murray, 2008).

Applicable to All Nurses

Nursing has often overlooked the responsibility to the patient held by nurses who are not in clinical roles. It is worth noting that nurse researchers, administrators, and educators are indirectly but still involved in supporting patient care. According to Fowler (2001), “it is not the possession of nursing credentials, degrees, and position that makes a nurse a nurse, rather it is this very commitment to the patient” (p. 435). Therefore, the code applies to all nurses regardless of their role.

The Principle of Respect for Autonomy

The principle of respect for autonomy holds that people should decide for themselves how they want to live their lives, as long as it does not harm others. Autonomy is the right to self-determination, even if the healthcare provider disagrees with that decision (Catalano, 1994). Within healthcare, this would mean that the patient has the capacity to act intentionally and with understanding, and without controlling influences that would mitigate against a free and voluntary act (McCormick, 1998). This principle is the basis for the practice of informed consent. However, under certain conditions, limitation can be imposed on a patient’s right to refuse treatment, such as with contagious diseases and tuberculosis cases (Catalano, 1994).

The Principle of Non-maleficence

The principle of non-maleficence requires that a healthcare provider not intentionally create unnecessary harm or injury to the patient, either through acts of commission or omission. This principle affirms the need for competence in providing care (McCormick, 1998). This is sometimes violated in the short term to produce a greater good for the patient in the long term. This principle is extended to require healthcare providers to protect those from harm who cannot protect themselves, i.e., children, unconscious patients, mentally incompetent, etc. (Catalano, 1994).

Failure to provide necessary health education to a patient who has a chronic health condition is an example of unethical behavior concerning the principle of non-maleficence. By withholding the necessary knowledge that is essential for understanding, needless worry and feelings of inferiority may be created in the patient. Nurses are not only ethically obligated to provide updated patient education, but are legally obligated as well

The principle of beneficence

The principle of beneficence is the active doing of goodness or kindness, requiring the nurse to act in ways to promote the patient’s welfare (Burkhardt & Nathaniel, 1998; Mappes & Degrazia, 2002). These goals are applied both to individual patients, as well as the good of society as a whole. An example of this is the provision of good healthcare as an appropriate goal with the individual, and the prevention of disease through research and administration of vaccines to the public (McCormick, 1998).

McCormick (1998) argues that beneficence is of limited duty. A healthcare provider has the duty to seek the benefit of all patients; however, they may also select whom they wish to admit into their practice. This duty may become complex and some criteria of urgency of need might need to be used to decide who should receive care.

The principle of justice

The principle of justice is an obligation to be fair to all. This may be expanded to distributive justice, which states that a person has the right to be treated equally regardless of sex, race, marital status, medical diagnosis, social standing, economic level, or religious belief (Catalano, 1994). McCormick (1998) argues that distributive justice implies the fair distribution of goods in society and requires that we look at the role of entitlement.

The question of who has the right to healthcare is one of our country’s most controversial issues. Medicare, which is available to everyone over the age of 65, is born out of the principle of justice.

Conflicting principles

One might argue that we are required to take all of the above principles into account when considering a clinical case. However, when two or more principles apply, we may find they are in conflict. An example of this might occur when a patient is diagnosed with acute appendicitis. The healthcare goal should be to provide the greatest benefit to the patient and proceed with immediate surgery. On the other hand, anesthesia and surgery carry some risk to an otherwise healthy patient, and we are under an obligation not to harm to the patient. Rationale would hold that the patient is in far greater danger from harm from a ruptured appendix than from the surgical procedure and anesthesia if the patient is taken to surgery (McCormick, 1998).

Achieving balance between the demands of these principles is necessary, and determining which principle carries the greater weight aides in making the correct choice in how to proceed (McCormick, 1998). In making an ethical decision, there are several approaches which may be utilized; the utilitarian approach examines which actions result in the most good and least harm; the rights based approach which examines which actions respect the rights of everyone involved; the fairness or justice approach which examines which actions treat people fairly; the common good approach which examines which actions contribute most to the quality of life of the affected people; and the virtue approach which embodies valued character strength (Swinton, 2007).

Moral courage

When confronted with an ethical dilemma, nurses must demonstrate moral courage by overcoming their fears and face the situation head on (Fowler & Benner, 2001). Moral courage is speaking out and taking the right course of action, even when constraints or forces to do otherwise are present. Lachman (2007) argues that moral courage turns principles into actions. When nurses demonstrate moral courage, they make a personal sacrifice by possibly standing alone, but at the same time will have a sense of peace in their decision to do what is right.

Examples of moral courage include confronting or reporting a peer who has diverted or is using drugs, or confronting a physician who has ordered a questionable treatment that is not within the standard of care.

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**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee’s identity, please check the license number. Every discipline case is different. Each case is considered separately by the Board. Every case contains factors, too numerous to list here, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any one case should not be viewed as Board policy and do not bind the Board in future cases.

CEASE & DESIST

Hank Sanderson, Julie A.
Liberty, MO

TEMP-Registered Nurse 2012025343

Patient A had a physician order for 1 tablet of Norco 5/325 as needed for pain and 1 tablet of Motrin as needed for pain every 4 hours. On November 5, 2012, at 19:00, licensee documented she administered Motrin. At 19:05, licensee documented a pain assessment. At 19:16:51 she withdrew Norco 5/325 from the Pyxis. At 19:05, licensee documented she administered the Norco. At 19:16, licensee documented she withdrew Motrin from the Pyxis. At 19:30, she documented she administered Motrin. At 20:30, licensee documented a pain assessment. At 23:42, licensee withdrew Motrin from the Pyxis and at 23:43:09, withdrew Norco 5/325. Licensee documented she administered the Norco at 23:30 and administered the Motrin at 23:57. Licensee failed to do a pain assessment after administering these doses. The patient reported she did not get pain relief from the first two (2) administrations of Norco but did get relief from the third administration leading the patient to believe Licensee did not actually administer Norco on the first two (2) occasions. On November 6, 2012, at 02:23, Licensee withdrew Motrin from the Pyxis and at 02:24:03, Licensee withdrew Norco 5/325 from the Pyxis. Licensee documented the administration of both the Norco and Motrin at 02:30. Licensee administered these pills prior to the time they should have been administered in contravention of physician orders and failed to document any pain assessments. On November 6, 2012, patient A gave the oncoming nurse a pill that had been given to her by Licensee for pain. Licensee had informed patient A the pill was Norco but the patient noticed that the pill was a different color. The pill was taken to the pharmacy which verified that the pill Licensee gave to patient A was Tylenol. Patient B had a physician order for 1 tablet of Norco 10/325 every 4 hours as needed for pain or for pain unresponsive to Norco 5/325 or to Motrin and Tylenol #3. The patient also had a physician order for Motrin 400-800 milligrams every 4 hours as needed for pain. On November 5, 2012, Licensee documented a pain assessment. At 19:30 Licensee documented she administered both Motrin and Norco 10/325. The Pyxis report shows that licensee did not withdraw Motrin and Norco 10/325 for this patient until 19:33:61 and 19:34. A pain reassessment was done at 20:45. The patient’s pain levels had been responding to Motrin and Tylenol #3; thus, administering Norco 10/325 was beyond the physician’s orders. The patient denied needing pain medication although Licensee reported to the oncoming nurse that the patient had complained of increased pain. Patient C had physician’s orders for Norco 10/325, 1 tablet every 4 hours as needed for severe pain or if pain was unresponsive to Norco 5/325. Patient C also had orders for Motrin every 4 hours as needed for pain. On November 5, 2012 at 20:00, Licensee documented she administered Motrin and Norco. The Pyxis report shows Licensee did not withdraw Motrin until 20:08. The Pyxis report also shows Licensee withdrew Norco 10/325 at 20:08:47. No pain assessments were done on Patient C. On November 6, 2012 at 02:17:02, the Pyxis report shows Licensee withdrew Norco 10/325. It is documented that Motrin and Norco were administered at 02:30. No pain assessments are documented either before the administration or after the administration. Patients A, B and C reported to the day nurse that the pills that Licensee administered were oval in shape and white in color. Norco 10/325 is yellow in color and oblong in shape. Patients A, B and C also reported to the day nurse the pain pills they received from Licensee did not help as much with pain as the pain pills received from the day nurse. The pills Licensee gave to patients A, B and C were given in a plastic cup rather than Licensee opening the pills in the bubble pack in front of the patients.

Cease / Desist 05/09/2013

CENSURE

Reed, Russell A.
Jefferson City, MO

Registered Nurse 137581

Respondent has failed to call in to NTS on one (1) day, August 25, 2011. Further, on December 19, 2011, February 16, 2012 and October 10, 2012, Respondent called NTS and was advised that he had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide

CENSURE Continued....

the requested sample on each of those days. In addition, on two separate occasions, January 4, 2012 and June 5, 2012, Respondent reported to lab and submitted the required sample which showed a low creatinine reading. On January 4, 2012, the low creatinine reading was 19.2. On June 5, 2012, the low creatinine reading was 14.8.
Censure 03/27/2013 to 03/28/2013

Thomas, Amanda Sue
Washington, MO

Licensed Practical Nurse 2011031807

Licensee was responsible for doing blood sugar checks on residents using a glucometer. Licensee felt ill and completed checks on three residents. Licensee found a co-worker to replace her on her shift and prepared to leave when she became aware three other residents needed blood sugar checks and had not yet had them. Licensee then falsely documented that the three remaining blood sugar checks had been completed and left the facility. After licensee initially denied falsifying the checks, she then admitted that she had in fact falsified them.
Censure 04/03/2013 to 04/04/2013

Munson, Deborah Sodek
Kansas City, MO

Registered Nurse 068326

Licensee practiced nursing in Missouri without a license from May 1, 2011, through December 3, 2012.
Censure 04/30/2013 to 05/01/2013

Strodtman, Lynda Danette
O’Fallon, MO

Registered Nurse 2001021198

On September 16, 2011, Licensee approached a physician and asked him to write three prescriptions for her brother who did not have insurance. The physician agreed to write the prescriptions for Licensee’s brother based on medical information he had at the time. He stated he would write a one to two week supply of the medications. Licensee represented herself as a co-worker of Licensee when she called in the prescriptions to the pharmacy. Licensee called in the prescription to the pharmacy in her name instead of her brother’s name. Licensee called in Famvar 500 mg, Risperdal 2 mg and Elimate. Licensee increased the amount of medication for which the physician wrote the order.
Censure 04/03/2013 to 04/04/2013

Huxhold, Debbie K.
Dunnegan, MO

Licensed Practical Nurse 038987

On November 1 and 2, 2012, Licensee worked the 6pm to 6am night shift at the facility as the only LPN assigned to that shift, and had many residents assigned to her care. On both of the above dates, licensee left the facility at the end of her shift without giving report to the oncoming day shift LPN. Video surveillance by the facility showed licensee leaving the facility at 0605 am and returning at 0626 am on November 1, 2012. Video surveillance by the facility showed licensee leaving the facility at 0605 am and returning at 0624 am on November 2, 2012. Although licensee did return to the facility on both occasions, her actions resulted in the oncoming LPN being uninformed of the status of each resident and unable to properly assume her duties to properly care for the residents of the facility, who were all non-verbal and non-ambulatory. Censure 05/25/2013 to 05/26/2013

Robertson, Laurie L.
Fairview Heights, IL

Registered Nurse 114124

The Illinois Board of Nursing disciplined Licensee’s nursing license upon grounds for which suspension or revocation is authorized in Missouri.
Censure 05/17/2013 to 05/18/2013

Anderson, Margie L.
Moberly, MO

Registered Nurse 091282

On May 10, 2010, Respondent turned in her timesheet and nursing notes for the prior week. Respondent’s supervisor noted that the documentation that Respondent turned in included nursing notes for her shift on May 2, 2010. Respondent had called in sick and did not work her shift on May 2, 2010, which began at 11:00 p.m. The documentation that Respondent turned in for May 2, 2010 included detailed nursing notes, vital signs, and observations on patient. When confronted, Respondent admitted that she falsified the nursing notes for patient. Respondent admitted that she did not work her shift on May 2, 2010 because she called in sick. Respondent admitted that on a nightly basis she had pre-filled her flow sheets with information that she “knows” never changes. Respondent knowingly falsified her May 2, 2010 nursing notes pertaining to patient care.
Censure 03/27/2013 to 03/28/2013

The Board of Nursing is requesting contact from the following individuals:

Melissa Farmer–PN2002022370
Jamie Henke–RN110458
Ashley Hurley–PN2003016522
Stacy Johnston–PN2007016299
Christine Larkin–PN045845
Holly McFadden–RN2007014364
Tara Neal–PN2008029212
Sherri Pelecanos–RN069541
Keisha Stone–RN2004006343

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CENSURE continued from page 13

White, Scotty L.
Bernie, MO
Licensed Practical Nurse 057501
On January 24, 2008, Respondent, an LPN, administered Toradol by IV push rather than IM, which was also contrary to physician’s orders.
Censure 04/01/2013 to 04/02/2013

Colbert, Stephanie Marie
Lathrop, MO
Registered Nurse 2008021154
Respondent was advised by certified mail to attend a meeting with the Board’s representative on March 14, 2012. Respondent did not attend the meeting or contact the Board to reschedule the meeting. Respondent was required to obtain continuing education hours and have the certificate of completion for all hours for all of those categories submitted to the Board by December 31, 2012. She faxed proof of completion on February 6, 2013.
Censure 03/27/2013 to 03/28/2013

Rossi, Karin Lynne
Hartsburg, MO
Registered Nurse 2001014016
Licensee failed to contact NTS on fourteen occasions, submitted two samples with low creatinine levels, and failed to submit an employer evaluation by the documentation due date.
Censure 03/20/2013 to 03/21/2013

Pearce, Juanita K.
Ozark, MO
Registered Nurse 122350
On January 2, 2011, Dr. W called Licensee and requested that she meet her at the hospital for a patient who required dialysis. Licensee stated that she received a verbal order to begin dialysis. When Dr. W arrived at the hospital, Licensee had already begun dialysis on the patient, but did not chart a verbal order from Dr. W. On November 19, 2010, Licensee was assigned a patient to be placed on dialysis. This dialysis patient had a new subclavian catheter for dialysis that had not yet been used and Licensee did not know if a physician had confirmed that the catheter was properly placed. The patient had had a chest x-ray earlier in the day, but no physician notes reflected whether the catheter was in the proper position. Licensee ordered a copy of the patient’s recent x-ray, reviewed the x-ray and concluded that the subclavian catheter was in the proper position and then began hemodialysis without confirming that a physician had read the x-ray and confirmed the proper placement of the subclavian catheter.
Censure 03/01/2013 to 03/02/2013

Vogel, Mary Dee
Tonganoxie, KS
Registered Nurse 2002019679
Patient MD was discharged from the hospital on December 30, 2011 on blood-thinning medication and with physician’s orders for home health and protime/INR lab testing. The Home Health Policy of the Hospital required “that the initial visit must be made within 48 hours from the patient’s discharge from an in-patient facility, receipt of referral or physician order to start care.” MD insisted on waiting to be admitted to home health, and Licensee acquiesced to his request. Licensee did not notify the physician that MD was not admitted into home health services by that date and did not document why the admission was delayed. MD continued to exhibit reluctance to home health, and as such, Licensee was not able to complete the admission process on January 3, 2012. Licensee did not check the INR by checking his blood on that date. Licensee instructed MD to have his INR checked at his doctor’s office, and she notified MD’s son-in-law of the situation. Licensee was able to complete the admission process, and checked the INR of MD by fingerstick at his home on Wednesday, January 4, 2012. Licensee received the error message “#7.” This error message indicated a high INR of MD’s blood, meaning MD may possibly have extremely thin blood, which may be life-threatening. On January 4, 2012, Licensee collected a blood specimen via venapuncture from MD and took it to the hospital’s lab. This specimen was later found to be inadequate. On January 5, 2012, Licensee again visited MD’s home to perform a finger stick and again received the same error message “#7” after using the coag machine. Licensee informed the patient to take a 325 mg aspirin (ASA) without a physician’s order. Aspirin may also be used to thin blood. Licensee incorrectly assumed that patient MD’s blood was too thick, but in reality it was too thin. On January 5, 2012, at the request of Licensee, another RN came to MD’s home and collected a second blood specimen via venapuncture. Immediately upon receiving the high INR result via telephone from the lab, Licensee called the office of MD’s physician. She then reported it to MD’s relative who held a durable power of attorney for MD. MD was then admitted to the hospital after his visit to the ER. MD had a history of INR management problems. On the above occasion, the INR result of MD’s blood when analyzed at the hospital’s lab was 19.1. Licensee did not document or report the lab results of the INR to her supervisor at the hospital until January 8, 2012.
Censure 03/01/2013 to 03/02/2013

Alexander, Sheri Lynn
Saint Charles, MO
Registered Nurse 2012001385
From January 26, 2012, through January 24, 2013, Respondent has failed to call in to NTS on five (5) different days. In addition, on one occasion, February 22, 2012, Respondent reported to a lab and submitted the required sample which showed a low

CENSURE Continued....

creatinine reading of 16.9. On January 15, 2013, Respondent submitted a required urine sample for random drug screening. That sample tested positive for the presence of Tramadol. Respondent does not, and did not, have a current, valid prescription for Tramadol on the date in question.
Censure 03/27/2013 to 03/28/2013

Lee, Suzanne Jean
Saint Louis, MO
Registered Nurse 2007027791
On April 15, 2012, Licensee made inappropriate verbal remarks to a patient.
Censure 04/25/2013 to 04/26/2013

Dixon, Holly M.
Louisburg, KS
Registered Nurse 116478
Licensee failed to contact NTS on six occasions, failed to provide a sample for testing on one occasion, and by submitted five samples with low creatinine levels.
Censure 03/19/2013 to 03/20/2013

Muhs, Melissa Ann
Lampe, MO
Registered Nurse 2001019770
From October 2, 2010, until the filing of this Probation Violation Complaint, Respondent has failed to call in to NTS on twenty-four (24) different days. On February 18, 2013, Respondent was selected to be tested when she called in to NTS for random drug and alcohol testing and was prompted to report for testing. Respondent failed to submit to a random test.
Censure 03/27/2013 to 03/28/2013

Castor, Kelly R.
Farmington, MO
Licensed Practical Nurse 050054
Licensee submitted a sample that tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol.
Censure 03/26/2013 to 03/27/2013

Schaub, Michael Shane
Saint Charles, MO
Registered Nurse 2002018672
From April 1, 2011 to January 25, 2013, Respondent failed to call in to NTS on sixteen (16) separate days. In addition, on May 23, 2011, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. The low creatinine reading on that date was 19.10.
Censure 04/01/2013 to 04/02/2013

Gibson, Mark Ansel
Moberly, MO
Licensed Practical Nurse 2010032186
Licensee was employed as a licensed practical nurse at the Center. Licensee’s duties involved patient care on the behavioral unit of the Center. On July 19-20, 2012, Licensee worked the 6pm-6am shift at the Center with two CNA’s and a CMT. On his shift, licensee was verbally abusive to residents by being short-tempered, rude, disrespectful and using crude and foul language towards them. He also denied several requests for assistance from residents without justification. Licensee also during this shift engaged in “horseplay” in conjunction with a CNA, and harassed and bullied a third CNA while the CNA was attempting to work. Censure 03/15/2013 to 03/16/2013

Payne, Pamela J.
Doniphan, MO
Registered Nurse 2011007270
Respondent failed to call NTS on eighteen (18) days.
Censure 03/19/2013 to 03/20/2013

Morris, Cheri Lynn
Springfield, MO
Registered Nurse 2005006900
The Board did not receive a thorough mental health evaluation submitted on Respondent’s behalf by the due date, but did receive one late.
Censure 03/22/2013 to 03/23/2013

Moore, Joshua N., Jr
Grandview, MO
Registered Nurse 135685
On June 16, 2012, Licensee performed dialysis on a patient without physician orders and falsely put the physician’s name on the patient’s orders without first speaking with the physician and without the physician’s knowledge.
Censure 05/08/2013 to 05/09/2013

PROBATION

Smith, Bridget Susan
Independence, MO
Registered Nurse 2011005705
On June 10, 2012, it was reported that Licensee was falling asleep and slurring her words. The nurse manager requested that Licensee take a for-cause drug test. Licensee admitted to the nurse manager that she had been on a float trip the previous weekend and had smoked some marijuana. Licensee also stated that she had taken some medication for back pain and seizures before coming to work. Licensee tested positive for marijuana.
Probation 05/25/2013 to 05/25/2018

PROBATION Continued....

Roland, Sandra L.
Kansas City, KS
Registered Nurse 122217
On April 1, 2005, Licensee pled guilty to making a false claim to the Medicaid program Probation 03/04/2013 to 03/04/2015

Keeland, Nicole E.
Springfield, MO
Licensed Practical Nurse 058556
On October 4, 2012, Licensee pled guilty to the crime of use of a communication facility to facilitate the distribution of a mixture or substance containing a detectable amount of cocaine, a controlled substance
Probation 05/02/2013 to 05/02/2018

Rhodes, Sandra L.
Blue Springs, MO
Licensed Practical Nurse 2009010471
In March, 2011, an investigation into why the patient’s wound was getting worse instead of better was conducted. On March 19, 2011, a culture was done on the patient’s wound which showed the growth of E Coli. Antibiotics were started immediately. It was later determined that Respondent failed to change this patient’s dressing as directed by the physician during her shift Respondent was responsible for changing the dressing for these patients, although treatment was not being done. Respondent worked from 7:00 p.m. March 21, 2011, to 7:00 a.m. March 22, 2011, and was responsible for patient, L.B. Respondent initialed on patient, L.B.’s, MAR that she changed the patient’s dressing during her shift. The dressing that was found on patient, L.B., during the shift of March 23, 2011 to March 24, 2011 was the dressing from March 20, 2011, which was dated and initialed by C.S. Respondent worked March 25, 2011, March 26, 2011, and March 27, 2011. She was responsible for patient, L.B. Respondent initialed on patient, L.B.’s, MAR that she changed the patient’s dressing during her shift. The dressing that was found on patient, L.B., during the next shift (March 28, 2011 to March 29, 2011) was the dressing from March 23, 2011, which was dated and initialed by C.S. Respondent worked March 25, 2011, March 26, 2011, and March 27, 2011. She was responsible for patient, A.D. Respondent initialed on patient, A.D.’s, MAR that she changed the patient’s dressing during her shift. The dressing that was found on patient, A.D., during the next shift (March 28, 2011 to March 29, 2011) was the dressing from March 24, 2011. Respondent worked from 7:00 p.m. March 30, 2011, to 7:00 a.m. April 1, 2011, and was responsible for patient, A.D. Respondent initialed on patient, A.D.’s, MAR that she changed the patient’s dressing during her shift. The dressing that was found on patient, A.D., during the next night shift (April 1, 2011, to April 3, 2011) was the dressing from March 29, 2011, which was dated and initialed by C.S. On several different patients, Respondent indicated in their charts that they received their medications and/or tube feeding medications. In reviewing the patient’s MAR and their medication bubble packs, V.W. was able to determine that these patients were not getting their medications during Respondent’s shifts.
Probation 03/25/2013 to 03/25/2015

Harrison, Paula Jo
Jefferson City, MO
Registered Nurse 2008024149
On October 5, 2011 the pharmacy called the Department with questions about prescriptions issued by Dr. B.C. regarding patient “Paula Harrison” that had been called in and had been written. The pharmacy faxed the following prescriptions to the department for the patient “Paula Harrison:” June 3, 2011 Norco 10/325 ninety tabs with one refill; March 11, 2011 Norco ninety tabs, refill; February 9, 2011 Norco 10/325 ninety tabs one refill; March 30, 2011 Vicodin 5/500 number ninety and Phenergan 25mg number fifty. A total of twelve prescriptions had been placed in her name. Dr. C. stated he did not authorize any of the prescriptions. Licensee was arrested on October 12, 2011 for fraudulently attempting to obtain a controlled substance. On April 4, 2012, Licensee appeared in the Circuit Court of Cole County, Missouri on the charge of fraudulently attempting to obtain a controlled substance, a class D felony and was referred to the Alternative Court Program. If she successfully completes the program, the charges will be dismissed.
Probation 05/25/2013 to 05/25/2018

LaBelle, Desiree Cheri
Jackson, MO
Registered Nurse 2008021449
On December 26, 2010, Licensee removed medications from the Pyxis system at the Facility prior to her shift beginning and prior to receiving the report authorizing medications to be removed and administered. In a thirty day audit, the Facility discovered that within the previous thirty days, Licensee removed 30 or more Dilaudid 2 mg syringes from the Pyxis system that Licensee did not document the administration or waste of the Dilaudid. Licensee admitted to Facility staff to diversion of Dilaudid for approximately six months. Licensee also produced “cups of medication” from her pocket and turned them over to hospital staff. The medications included two Dilaudid syringes (a third was not recovered), 1 ml of injectable Hydromorphone, 2 cc syringe of oral Acetylcysteine, 1000 mg of oral Cyclobenzaprine, 25 mg metoprolol, 10 mg hydrocodone birartrate, acetaminophen 5 mg/500 mg, trazodene HCP 50 mg, propoanolo HCL 20 mg and lamotrigine. Probation 05/25/2013 to 05/25/2018

Bell, Vivian Marie
East Saint Louis, IL
Licensed Practical Nurse 042586
On June 28, 2012, Licensee was caring for a hospice resident with terminal throat cancer. At 00:00, Licensee noted that the resident had a low grade fever and an oxygen saturation of 88 percent with nasal cannula. At 04:00, Licensee noted that the resident was found with nasal cannula removed and complaining of throat pain, oxygen saturation was 88 percent. Resident was given Roxinal and the nasal cannula was replaced. At 04:30, Licensee noted that the resident had removed the nasal cannula again and his oxygen saturation was 88 percent. Licensee replaced the nasal cannula. At 05:00 Licensee noted that resident’s oxygen saturation was 88 percent with no labored breathing. At 06:30, Licensee noted that resident’s oxygen saturation was 78 percent with nasal cannula in place. Licensee called the doctor. Licensee failed to inform the doctor that resident was a full code, that Roxinal had been given to resident, and that resident’s oxygen saturation had declined. The doctor ordered a nebulizer treatment which Licensee administered around 07:15. At 07:30, the resident was found not breathing. CPR was begun and 911 was called. Probation 05/25/2013 to 05/25/2014

Gibson, Shelly L.
Cosby, MO
Registered Nurse 150942
On February 8, 2010 Licensee entered a plea of guilty driving while intoxicated. On July 12, 2010 Licensee entered a plea of guilty to driving while intoxicated. Probation 03/19/2013 to 03/19/2016

McNeese, Marc Anthony
Belleville, IL
Registered Nurse 092314
Respondent pled guilty to the Class C felony of stealing \$500 or more by deceit. This conviction occurred on April 11, 2008. Probation 03/22/2013 to 03/22/2018

Mayfield, Karen G.
Kansas City, MO
Registered Nurse 079817
While employed at the hospital over the last several years from approximately 2009 through 2012, Licensee stole and diverted to herself for her own consumption injectable Nubain, Stadol, Phenergan and Benadryl on numerous occasions. Probation 03/01/2013 to 03/01/2018

Johnson, Kurtis F.
Paris, MO
Registered Nurse 149130
During the period of June 6, 2012 through June 7, 2012, Licensee worked at the Center and committed the following incidents at the Center. Licensee was instructed by a physician’s order to administer Calmoseptine cream to a patient’s decubitus ulcer over his shift, with the medication due to be administered at 6:00 am, 12:00 pm, and 8:00 pm. Licensee falsely recorded in the patient’s medical records that the doses due at 8:00 pm on June 6, 2012, and 6:00 am on June 7, 2012 were given, when in fact, they were not. When confronted by Center officials, licensee admitted that he had charted the medication as being given even though it had not been. Licensee stated that he noted the patient had been sleeping when the medication was due and that he forgot to change the documentation. Probation 04/25/2013 to 04/26/2013

Davis, Teresa Oleda
Waynesville, MO
Licensed Practical Nurse 2006024940
On June 27, 2012, Licensee pled guilty to driving while intoxicated; failure to drive on the right half of the roadway when the roadway was of sufficient width resulting in an accident; and, leaving the scene of a motor vehicle accident. Probation 03/01/2013 to 03/01/2018

Holcomb, Kelly Michelle
Poplar Bluff, MO
Registered Nurse 2013011428
On December 27, 2007, Applicant pled guilty to passing bad checks. On October 25, 2007, Applicant pled guilty to passing bad checks. On February 18, 2008, Applicant pled guilty to passing bad checks. On September 22, 2010, Applicant pled guilty to forgery. Probation 04/10/2013 to 04/10/2015

Henke, Jamie L.
Hazelwood, MO
Registered Nurse 110458
In October 2006, Respondent diverted twelve (12) doses of controlled substances from patient J.R. When confronted, Respondent admitted she diverted these controlled substances for personal use and consumed them. Probation 03/29/2013 to 03/29/2018

Jefferson, Christy Michelle
Richland, MO
Licensed Practical Nurse 2006037757
On June 20, 2008, Jefferson was caring for patient E.C. At around 8:00 p.m. staff members told Respondent that E.C. was complaining about shortness of breath. When Respondent went to check on E.C., E.C. asked Respondent to remove E.C.’s trach to clean it, and she asked for warm liquid. Respondent did so, but E.C. was still complaining of shortness of breath. Other staff members took E.C.’s vital signs, and her oxygen saturation was recorded at 44, which is extremely low. Respondent left E.C.’s room to call the doctor. Respondent informed the doctor of E.C.’s oxygen saturation level, but said that it was not correct because if it were that low, E.C. would not have been able to talk. Respondent disregarded E.C.’s oxygen saturation level. Respondent did not inform the doctor that E.C. was in respiratory distress. The doctor ordered Respondent to give E.C. Ativan and to wait 30 minutes. E.C. was in respiratory distress. Respondent approached another nurse, D.A., and asked how his relationship was with E.C., but did not say E.C. was in respiratory distress. About five to ten minutes later, D.A. went to check on E.C., and she appeared ashen. E.C. whispered, “Help me.” D.A. retrieved emergency supplies and determined that E.C.’s lungs were full of fluid. He proceeded to suction her lungs. Respondent approached another nurse, P.R., to check on E.C. as well. Respondent did not mention that E.C. was in respiratory distress. P.R. checked on her own patients first, and when she arrived in E.C.’s room, she assisted D.A. by doing chest compressions on E.C. When Respondent returned to E.C.’s room, she called 911. On June 20, 2008, Respondent failed to take E.C.’s vital signs, listen to E.C.’s lungs, suction E.C.’s lungs, and make accurate notes regarding E.C.’s condition. On June 20, 2008, E.C. was pronounced dead at 8:57 p.m. Probation 03/27/2013 to 03/27/2015

Marshall, Jennifer Lea
Blue Springs, MO
Licensed Practical Nurse 2004026206
During the time licensee was assigned to care for DM, the Licensee went to DM’s home and provided nursing services to her on a rotating shift basis, as DM was unable to care for herself. Licensee consumed alcoholic beverages while on duty in DM’s home on May 25, 2012. She also continued to stay in DM’s home and consume more alcoholic beverages after her shift ended that day. A co-worker who came to DM’s home for the next shift noted that licensee wasn’t acting “normal” and that licensee was noted to be slurring her words. Licensee admitted to the Board through a letter that she did consume alcohol in DM’s home. Probation 04/03/2013 to 04/03/2018

Harmon, Kelley A.
Kansas City, MO
Licensed Practical Nurse 053395
On May 20, 2011, Respondent submitted to a reasonable suspicion/ cause drug screen. The May 20, 2011 drug screen was positive for Marijuana. Probation 03/29/2013 to 03/29/2018

Bowling, Andrea R.
Elkland, MO
Licensed Practical Nurse 2000170832
The mother of a private duty patient reported that Licensee broke into a locked closet to steal the patient’s Hydrocodone. Hydrocodone had previously been stolen from the closet. Licensee was observed on video camera breaking into the locked closet. Licensee obtained tools and took the closet door off of its hinges and removed the door. Probation 03/01/2013 to 03/01/2016

Weeks, Vanessa Jean
Springfield, MO
Registered Nurse 2002005068
From October 21, 2011, through January 25, 2013, Respondent has failed to call in to NTS on eight (8) separate days. Further, on April 6, 2012 and again on October 8, 2012, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample on both of those days. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of December 24, 2012. The Board did receive an employer evaluation on February 4, 2013 with a letter from Respondent’s employer taking responsibility for faxing the evaluation late, which was on December 27, 2012. Probation 04/01/2013 to 04/01/2018

Covey, Jessica Michelle
Holt, MO
Licensed Practical Nurse 2002025171
On November 13, 2009, Respondent falsely documented having received a physician’s telephone order to administer oxycodone to Patient D.I. Respondent diverted this oxycodone for her own use. On November 14, 2009, Respondent falsely documented having received a physician’s telephone order to administer hydrocodone to Patient D.I. Respondent diverted this hydrocodone for her own use. On November 28, 2009, Respondent falsely documented having

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PROBATION continued from page 15

received a physician’s telephone order to administer oxycodone to Patient D.I. Respondent diverted this oxycodone for her own use. On November 29, 2009, Respondent falsely documented having received a physician’s telephone order to administer hydrocodone to Patient D.I. Respondent diverted this hydrocodone for her own use. On December 9, 2009, Respondent falsely documented having received a physician’s telephone order to administer oxycodone to Patient D.I. Respondent diverted this oxycodone for her own use. On December 24, 2009, Respondent falsely documented having received a physician’s telephone order to administer oxycodone to Patient D.I. Respondent diverted this oxycodone for her own use. Probation 04/03/2013 to 04/03/2018

Henderson, Donna M.
Kansas City, MO
Licensed Practical Nurse 055663
On June 12, 2007, Respondent was given a pre-employment drug screen and she tested positive for marijuana. The Kansas State Board of Nursing issued its order revoking the Kansas nursing license held by Respondent. Probation 04/01/2013 to 04/01/2018

Wilkinson, Carrie L.
Joplin, MO
Registered Nurse 150626
COUNT I
On July 29, 2009, while on duty, Wilkinson administered Toradol to a patient without a physician’s order. Wilkinson failed to document the withdrawal of Toradol from the medication inventory, failed to document the administration of Toradol on the patient’s chart, and failed to notify the oncoming nurse at shift change of the administration of Toradol to this patient. COUNT II
On May 31, 2010, Wilkinson was scheduled to care for a patient on a one-to-one basis, at the patient’s home, from 10:00 a.m. to 4:00 p.m. Wilkinson failed to report for duty until after 1:00 p.m. on May 31, 2010. However, she submitted a time sheet falsely claiming that she worked the entire shift. Probation 03/27/2013 to 03/27/2016

Yarbrough, Sherry L.
Naylor, MO
Registered Nurse 117004
Suspended from May 5, 2013 until May 11, 2013 and Probated from May 12, 2013 until December 28, 2015. Respondent failed to call in to NTS on ten more (10) days. Probation 05/12/2013 to 12/28/2015

Jones, Robyn C.
Ironton, MO
Registered Nurse 143017
On February 23, 2012, Licensee’s husband came into the clinic for treatment. Licensee treated and diagnosed her husband on her own with no supervision from the clinic’s advanced practice nurse (APRN) or the clinic’s physician. Licensee gave her husband two injections without physician orders or APRN approval and also phoned in a prescription for her husband for a “z-pack,” also without physician orders or APRN approval. Probation 04/25/2013 to 04/26/2013

Knupp, Patricia Jean
Olive Branch, IL
Licensed Practical Nurse 2006028259
Licensee was discovered having inappropriate contact with an inmate. Probation 03/01/2013 to 03/01/2015

Walzer, Kenya Monique
Grandview, MO
Registered Nurse 2006025384
On July 19, 2007, Respondent tested positive for methadone during a pre-employment drug screen. Respondent did not have a valid prescription to possess methadone. Probation 04/15/2013 to 04/15/2016

Winefeldt, Gail N.
Lockwood, MO
Licensed Practical Nurse 048746
On August 2, 2012 patient SH came in to the MRC complaining of back pain. Patient SH had been calling in for the previous week complaining of pain. The doctor treating SH was not in the office that day. There was another physician on duty, but Licensee did not speak to that physician about patient SH’s condition. Licensee gave patient SH an injection of Toradol without a doctor’s order Probation 03/15/2013 to 03/15/2014

Knehans, Robin Rachalle
Saint Louis, MO
Licensed Practical Nurse
On November 5, 2012, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol. Respondent was required to obtain continuing education hours and have the certificate of completion for all hours submitted to the Board by January 26, 2013. Respondent failed to submit proof of completion of continuing education classes by the documentation due date. On November 21, 2012, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading of 18.9. Probation 03/27/2013 to 01/26/2016

PROBATION Continued....

Neels, Emily Nicole
Arnold, MO
Licensed Practical Nurse 2006027894
While at MHS, Licensee was caring for a 2 year old patient in July 2011. The patient had a physician’s order for Clonidine 0.4 ml three times per day. On July 27, 2011, Licensee assessed the patient and determined that the patient had a low temperature and low heart rate. As a result, Licensee held back the 14:00 dose of Clonidine on July 27, 2011. Licensee attempted to contact the patient’s physician Dr. P. on July 27, 2011. Dr. P. did not return Licensee’s calls on July 27, 2011. Due to the Licensee’s assessment of the patient, Licensee also held the 1400 dose of Clonidine on July 28, 2011. Licensee attempted to contact the patient’s physician Dr. P. on July 28, 2011. Dr. P. did not return Licensee’s calls on July 28, 2011. On July 29, 2011 at 16:65 Licensee wrote a nurse’s note stating that she had decreased the dose of Clonidine to 0.4 ml every twelve hours after speaking with Dr. P. Licensee also documented that she notified her supervisor of the changes. Licensee did not speak with her supervisors regarding the situation. Licensee did not receive the medication order change from Dr. P. Probation 05/09/2013 to 05/16/2013

Gomez, Ricki J.
Nevada, MO
Licensed Practical Nurse 058615
On June 6, 2004, Licensee was found guilty of twenty-seven (27) counts of possession of methamphetamine with intent to distribute. Probation 03/04/2013 to 03/04/2016

Cornman, Sarah Elizabeth
Bourbon, MO
Registered Nurse 2001021173
From February 7, 2012, until February 13, 2013, Respondent has failed to call in to NTS on ten (10) days. Probation 03/22/2013 to 08/17/2015

Niedbalski, Kathleen W.
Saint Louis, MO
Registered Nurse 2005027251
While employed at the Hospital, between February 1, 2012 through February 29, 2012, Licensee stole and diverted to herself three and a half ampoules (total of 350 micrograms) of Fentanyl from the Hospital. While employed at the Hospital, between March 1, 2012 through March 31, 2012, Licensee stole and diverted to herself thirty ampoules (total of 3,000 micrograms) of Fentanyl from the Hospital. On April 5, 2012, Licensee admitted taking the Fentanyl for her personal use. Probation 03/19/2013 to 03/19/2018

Loza Hernandez, Sonia Maritza
Saint Louis, MO
Registered Nurse 2008029951
At 8:02 am, EM received his breakfast tray and his skin color appeared normal. At 8:07 am, Licensee noted that EM was pale and unresponsive while seated in the dining room. EM was taken from the dining room back to his room. At 8:10 am, Licensee determined that EM had no pulse, no respirations, and no blood pressure. At 8:40 am, Licensee informed EM’s family that he had passed away. At 9:00 am, Licensee attempted to contact EM’s doctor about EM’s condition. At 9:25 am, the coroner/medical examiner was contacted about EM’s death. At 9:30 am, Licensee contacted 911. Patient EM was a full code which required facility staff to initiate CPR and immediately call 911 when a patient is found unresponsive. Because of her actions in this situation, Licensee was placed on the Employee Disqualification List kept by the Missouri Department of Health and Senior Services for three (3) years. Probation 04/25/2013 to 04/25/2016

Schimmer, Mary Ashley
Grain Valley, MO
Registered Nurse 2009003868
COUNT I
On September 15, 2010, Respondent reported to work and was asked to submit to a for cause drug screen. Respondent’s drug test was positive for Fentanyl and Norfentanyl. On October 4, 2010, Respondent received a letter outlining the conditions upon which her employment would continue. Respondent signed the letter of October 4, 2010 agreeing to the terms set out in the letter. On November 5, 2010, Respondent reported to work and was asked to submit to a random drug screen. Respondent’s November 5, 2010 drug test was positive for Hydrocodone. Respondent did present a valid prescription for Hydrocodone. COUNT II
On August 2, 2011, Respondent forged a prescription for Percocet. On July 24, 2011 and July 25, 2011, Respondent forged two prescriptions for Hydrocodone without the doctor’s knowledge or consent. Respondent stole blank prescription pads and wrote fraudulent prescriptions in an attempt to obtain controlled substances for her own personal use. Probation 03/25/2013 to 03/25/2018

Dale, Martha Jane
Liberty, MO
Licensed Practical Nurse 2013006625
Licensee disclosed that she had a criminal history and that disciplinary action had been taken against her Texas licensed practical nursing license by the Texas Board of Nursing. On November 9, 2010, Licensee was found guilty of driving while intoxicated. On November 9, 2010, Licensee was found guilty of driving while intoxicated. On March 15, 2011, Licensee was found guilty of driving while intoxicated. On September 16,

PROBATION Continued....

2010, Licensee entered into an agreement with the Texas Peer Assistance Program for Nurses (TPAPN). She did not complete the program due to moving to Missouri. Probation 03/05/2013 to 03/05/2016

Neeley, Charles Joshua
Kansas City, MO
Licensed Practical Nurse 2013015865
On August 11, 2012, Applicant failed the NCLEX. On the same day, he interviewed for a LPN position and began employment on September 7, 2012. By the time he had begun employment, he had received the exam result letter stating that he had failed the exam. The letter explains in bold print that he can no longer work as a graduate nurse. Applicant did not disclose to his employer that he failed the exam. When questioned about the exam, Applicant told his employer that he had not taken the exam yet, but was scheduled to take the exam on October 6, 2012. On October 6, 2012, Applicant appeared at the testing site to take the exam, but failed to bring his paperwork and was turned away. On October 10, 2012, Applicant’s employer called the Board and found out that Applicant could not work as a graduate nurse. Applicant was then terminated. Probation 05/22/2013 to 06/06/2013

Burstein, Dawn Jeanette
Ballwin, MO
Registered Nurse 2008005251
On October 7, 2009, Licensee admitted to her employer that she had been diverting narcotic medications for her own personal use. Licensee was placed on a Return to Work Agreement on November 2, 2009 for two years under specific conditions. In March of 2011, the EAP counselor reported that the Licensee was not following her responsibilities as outlined in the Return to Work Agreement. On March 8, 2011, Licensee was terminated for failing to comply with the requirements of the Return to Work Agreement. Licensee later admitted to the Board investigator that she diverted controlled substances in October 2009 for her personal use. Probation 04/30/2013 to 04/30/2016

McKeel, Tiffany Renee
Grain Valley, MO
Registered Nurse 2013010121
On June 12, 2009, Licensee was observed to be displaying suspicious behavior. On June 15, 2009, Licensee admitted to diverting wasted narcotics from the sharps container. Licensee further admitted she typically used the diverted drugs off duty, but on “some occasions” used the narcotics while on duty. On June 17, 2009, the result from Licensee’s drug screen was received and was positive for hydromorphone, morphine and fentanyl. Licensee entered into a settlement agreement with the Board. Licensee failed to contract with NTS and therefore her Missouri nursing license number RN 2006019195 was revoked for failure to comply with the terms and conditions of the agreement. On May 17, 2012, Licensee submitted her Application for License as a Registered Professional Nurse by Examination. With her Application, Licensee disclosed that she had entered a diversionary program after being charged with fraudulently attempting to obtain a controlled substance, a class D felony. The charges were dismissed on July 19, 2012, after she successfully completed the program. Probation 03/25/2013 to 03/25/2018

REVOCATION

Brownfield, Sheri Sue
Marshall, MO
Licensed Practical Nurse 1999136112
Respondent was required to submit drug screen results from Drug Court on a quarterly basis for the duration of drug court, beginning on May 29, 2012. Respondent never submitted quarterly reports, but a report in the form of an email from Respondent’s probation officer from Drug Court was sent on September 12, 2012 to the Board which stated that Respondent had been compliant with her treatment and tested negative on all urine tests required through that date. The Board has not received any information since that date on any further drug testing of Respondent, that the drug court has either ended or is continuing its tests of Respondent, or that if the Drug Court has ended, that Respondent has signed up with the Board’s third-party tester, NTS, to begin drug testing for the rest of the period of her five year probation. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of November 29, 2012. The Board did not receive a continuing chemical dependency evaluation by the documentation due date of November 29, 2012. Revoked 03/27/2013

Smith, Cathy Lin
Centerview, MO
Registered Nurse 2003002349
Licensee failed to contact NTS on four occasions and failed to show a copy of her Agreement with the Board to her prescribing physician. Revoked 03/26/2013

Bynog, Tracy
Lena, LA
Licensed Practical Nurse 058788
Respondent tested positive for barbiturates, cocaine, and propoxyphene. Respondent did not have a prescription for either cocaine or propoxyphene.
Revoked 03/19/2013

Noval, Andrew Peter
Kansas City, MO
Licensed Practical Nurse 2006014906
In December 2009, Licensee failed to properly assess a resident post fall, and failed to get the resident the critical care that was needed. Licensee failed to properly chart the resident’s vital signs post fall.
Revoked 03/19/2013

Riley, Stacey Anne
Monticello, AR
Licensed Practical Nurse 2008023842
On February 8, 2010, while on duty, Respondent phoned in a prescription for 120 hydrocodone tablets. She used a co-worker’s name to phone in the prescription and her niece’s name as the alleged patient for the prescription. Later on February 8, 2010, Respondent received the hydrocodone and diverted the medication for her personal use. On March 2, 2010, while on duty, Respondent phoned in a prescription for 120 hydrocodone tablets. She used a co-worker’s name to phone in the prescription and her niece’s name as the alleged patient for the prescription.
Revoked 03/19/2013

Clark, Karen Sue
Columbia, MO
Registered Nurse 2007000466
On January 4, 2013, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a laboratory to provide the requested sample. Also, on December 17, 2012, Respondent reported to a collection site to provide a sample after being prompted to do so and the sample tested positive for Ethyl Glucuronide (EtG), a metabolite of alcohol.
Revoked 03/27/2013

Young-Ederle, Susan R.
O Fallon, MO
Registered Nurse 121963
On April 24, 2008, Respondent did not respond to call lights or clean rooms. On April 28, 2008, while Respondent was on duty at the triage desk, three patients entered in need of triage between 8:00am-8:45am. Respondent refused to attend to these patients’ needs and instead sat at her desk checking e-mail. These patients were ultimately triaged by Respondent’s co-workers. On April 30, 2008, while on duty, Respondent stated, “I don’t like doing that kind of patient,” in reference to a patient suffering from exposure. When directed to provide care for the patient, Respondent announced she was taking a meal break and delayed treatment by 28 minutes.
Revoked 03/19/2013

Noel, Jacqueline M.
Columbia, MO
Registered Nurse 106700
Respondent has failed to call in to NTS on three (3) separate days. In addition, on three separate occasions, August 30, 2012, September 6, 2012, and November 27, 2012, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. Revoked 03/27/2013

Lowman, Ada Marie
Sikeston, MO
Licensed Practical Nurse 1999135108
On November 19, 2007, Licensee pled guilty to the Class C Felony of Stealing.
Revoked 03/21/2013

Johnson, Kandi Lea
Trenton, MO
Licensed Practical Nurse 2009030301
Respondent diverted hydrocodone pills and placed them in an older prescription bottle containing a label for hydrocodone in an attempt to cover her diversion.
Revoked 03/19/2013

Foster, Stephanie S.
Joplin, MO
Registered Nurse 2000161015
On January 22, 2008, while on duty, Respondent diverted morphine and codeine from patients under her care. She consumed these medications while on duty. On January 23, 2008, Respondent submitted to a drug screen that tested positive for codeine and morphine.
Revoked 03/19/2013

Anderson, Carla S.
Trenton, MO
Licensed Practical Nurse 045170
On October 14, 2009, she pled guilty to possession of a controlled substance. On March 11, 2004, she pled guilty to passing bad checks. Anderson was placed on the Employee Disqualification List, or “EDL,” by the Missouri Department of Health and Senior Services.
Revoked 03/19/2013

Chilson, Braida Pearline
Jackson, MI
Licensed Practical Nurse 2006020281
On October 31, 2006, Respondent caused the death of two people after she drove while intoxicated, crossed the center line, and engaged in a head-on collision with another vehicle. On June 22, 2010, a jury found Respondent guilty of two counts of involuntary manslaughter. Revoked 03/22/2013

Roman, Meredith Ann
Houston, TX
Registered Nurse 106239
On August 24, 2007, while on duty, Respondent transported a patient to another department for testing. She was to return to her department immediately to care for other patients. Instead, she remained with this patient, which forced other nurses in her department to care for her patients. Over the course of several weeks, it was discovered that Respondent failed to take patients’ vital signs and eventually completed their charts after the fact with information taken from “Trend Vitals in the Phillips Monitor.” When questioned about this information, Respondent admitted she failed to take vital signs and used “creative charting.” On another occasion, while on duty, Respondent came across a patient whose monitor was sounding an alarm. Respondent was unable to determine the reason for this alarm and did nothing to help the patient. Another nurse rushed in and realized the monitor indicated the patient was in ventricular fibrillation, and she started cardiopulmonary resuscitation.
Revoked 03/19/2013

White, Linda K.
Hurst, TX
Licensed Practical Nurse 052272
Respondent held a nursing license in New Mexico as an LPN. On December 14, 2006, Respondent’s New Mexico LPN license was revoked by that state’s Board of Nursing. Respondent’s New Mexico license was revoked for the following reason: Respondent diverted a controlled substance by fraudulently obtaining a physician’s blank, pre-signed prescription from her place of employment and forged it to obtain Roxicet. Respondent then diverted the Roxicet and consumed it for her own personal use.
Revoked 03/19/2013

Barker, Victoria Lynn
Buffalo, MO
Licensed Practical Nurse 038975
On April 9, 2008, Respondent was on duty. She was observed to have slurred speech, slowed reaction time, and appeared to be “half asleep.” Respondent tested positive for barbiturates, opiates, and benzodiazepines. She had a valid prescription for opiates and benzodiazepines, but not for barbiturates.
Revoked 03/19/2013

Martin, Gina Renea
Webb City, MO
Licensed Practical Nurse 1999140649
On November 30, 2008, Martin arrived for duty while under the influence of prescription medication. Martin fell asleep while attempting to adjust a patient’s IV pump. She also fell asleep later in the shift while standing and attempting to drink a beverage. Later, on that date, during her shift, Martin was directed by the nurse manager to leave work and submit to a drug screen. Martin admitted to the nurse manager that she consumed Klonopin prior to beginning her shift. Martin did not submit to a drug screen as directed.
Revoked 03/19/2013

Fritz, Sandra Jean
Wentzville, MO
Registered Nurse 2001005285
Between March 1, 2009, and March 30, 2009, Respondent diverted 58 doses of controlled substances.
Revoked 03/19/2013

Ross, Crystal G.
Branson, MO
Registered Nurse 152240
On December 16, 2008, police officers came to the Center for Respondent. Respondent asked the Director of Nursing if she could get her belongings before she went to the front, where the police officers were waiting. The Director agreed, handing over the keys to the medication cart to Respondent. Respondent unlocked the medication cart she had been using during her shift, opened the top drawer, and picked up two white envelopes. The Director asked her about the contents of the envelope. Respondent responded that she had Reglan pills because she had not filled her prescription for Reglan. The Director informed Respondent that she would not be able to take the two white envelopes with her. As a result, Respondent put the two envelopes into the red Sharps box, a medical waste disposal container. Respondent admitted that the pills were from residents’ medications. After escorting Respondent to the front of the building, the Director retrieved the envelopes that Respondent had placed in the box. Upon inspection, the Director determined that envelope 1 contained five Reglan and a half tablet of Percocet and envelope 2 contained two Percocet, one morphine, and one oxycodone tablet. Later that day Respondent returned, asking to work. The Director took her into an office with another colleague and confronted Respondent about the pills in the envelope. Respondent admitted that she took the pills to sell to her boyfriend’s sister because she and her boyfriend did not have money for groceries and cigarettes.
Revoked 03/19/2013

Plotner, Stephanie Ranae
Vienna, MO
Licensed Practical Nurse 2005031391
From April 14, 2011 through January 24, 2013, Respondent failed to call in to NTS on two (2) days. Further, on November 16, 2011; June 7, 2012; November 12, 2012 and December 12, 2012, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample on each of the above days. On January 10, 2012, Respondent submitted a urine sample as requested for random drug screening. That sample tested positive for the presence of Tramadol. Licensee did not have a current, valid prescription for Tramadol.
Revoked 04/01/2013

Dawson, Sandra Kay
Neosho, MO
Registered Nurse 2007007742
On July 23, 2008, while on duty, Dawson charted that she administered three doses of pain medication to a patient. Dawson charted that two of the doses administered to the patient were Lortab and one dose was Percocet. Patient never received this pain medication. On July 23, 2008, Dawson charted that she administered Lortab to a patient. Patient never received this pain

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REVOCATION continued from page 17

medication. On July 23, 2008, Dawson charted administering two doses of oxycodone to a patient. Patient only received one dose of oxycodone.
Revoked 03/19/2013

Dake, Sherri L.
Springfield, MO
Licensed Practical Nurse 040884

On April 4, 2011, Respondent was asked to submit to a drug screen. Respondent’s drug screen was positive for morphine. Respondent did not have a valid prescription for morphine. Respondent was working under the influence of a controlled substance while on duty.
Revoked 03/19/2013

Gundry, Debra A.
Saint Louis, MO
Licensed Practical Nurse 047615

On August 26, 2009, Respondent was observed pouring liquid Morphine and liquid Ativan into a cup and then drinking the contents. On August 26, 2009, Respondent poured a second cup of liquid Morphine and liquid Ativan into a cup and again drank the contents. Respondent then took the open bottles of liquid Morphine and liquid Ativan and filled them with water. Upon notifying a supervisor, a narcotic count was performed. There were no narcotics missing, but the bottles of liquid Morphine and liquid Ativan appeared to be watered down. When Respondent was confronted by a co-worker the evening of August 26, 2009, Respondent admitted that she had ingested the Morphine and the Ativan.
Revoked 03/19/2013

Meek, Rebecca A.
Trenton, MO
Licensed Practical Nurse 037332

Licensee did not notify the physician of a patient’s change in condition and did not initiate CPR on a full code patient. Because of these actions, Licensee’s name was placed on the Department of Health and Senior Services Employee Disqualification List.
Revoked 04/01/2013

Espey, Anita L.
Maryville, MO
Registered Nurse 082923

Respondent was placed on the EDL. Respondent admitted that patient seizures were not properly charted at the facility. Respondent admitted that patient PM had a specific five part treatment order from his physician that was not addressed or performed.
Revoked 04/01/2013

Tighe, Shellieanna Schaefer
Parkville, MO
Registered Nurse 2007017685

On June 10, 2011, Respondent withdrew Fentanyl. Respondent did not document the administration or waste of the Fentanyl. On June 11, 2011, Respondent withdrew Fentanyl. Respondent did not document the administration or waste of the Fentanyl at any time. On June 13, 2011, Respondent withdrew Hydromorphone. Respondent did not document the administration or waste of the Hydromorphone. On July 20, 2011, Respondent removed morphine from the medication drawer. Respondent told another nurse that she did not know “how to do a PCA.” When another staff member opened the drawer, only one PCA was remaining in the drawer. Based on hospital records, the count should have been two. Respondent was the last person to open the drawer before the staff discovered the miscount. On July 23, 2011, Respondent was in the medication room on the medication administration system when her shift had not yet started. Staff observed her in the medication room for an extraordinarily long time compared to the normal time to obtain medication. On July 25, 2011, the ICU charge nurse notified the hospital that she and two other staff members observed a 3 ml syringe without the needle attached in the women’s restroom. The syringe did not belong to any of those three staff members. Respondent was also on duty that night. Staff stated that Respondent appeared energetic at the beginning of her shift but later in the shift she appeared extremely tired. In the morning on July 26, 2011, Respondent appeared so tired and groggy when observed by the Director of the ICU that Respondent’s eyes would cross when she talked while standing up. On July 26, 2011, staff observed Respondent come out of the restroom with a bag that contained a 250 ml bag of 0.9% saline (NS) flush, a tourniquet, a syringe with butterfly needle, ten 20 ml syringes some with the initial ‘D’ or ‘F’, two 10 ml syringes, two saline flushes, eight open needles, an opened alcohol prep and 8 caps. When Respondent saw that staff observed this, Respondent threw the bag in the corner under the television. Two staff members saw her move the bag several times. The hospital conducted an investigation related to Respondent’s dispensing records for controlled substances. The investigation revealed that in June and July 2011, Respondent accessed medication dispensing units while in uniform at times when she was not scheduled to be on duty and had no patients assigned to her care. On July 26, 2011 at 19:00, a nurse observed Respondent at the facility dressed in scrubs with her badge on as if she was working when another nurse had agreed to work for her that shift. The nurse went to the medication room and observed Respondent in the medication refrigerator with a drawer pulled out and a “pea vial” in her hand. Respondent saw the nurse watching her and placed the vial back in the bin and closed the refrigerator. Respondent then left the medication room. Staff reported, and hospital records verified, that

REVOCATION Continued....

Respondent had been in the Accudose medication refrigerator but had cancelled the transaction, as if she had not gotten into the refrigerator, when she was observed with saline flushes and had asked someone to get her a 10 ml syringe. A staff member checked the medication refrigerators. It was determined that two Fentanyl syringes had been tampered with and the tape seal broken. The Accudose records showed that Respondent had entered the refrigerators several times for the past two (2) days during the day shift. It was determined that Respondent had prior access to the controlled substances immediately before discrepancies for 5 mg/ml injection of Morphine and 50 mcg/ml 2 ml injection of Fentanyl in the ICU. There were 10 doses of Morphine, 12 of Fentanyl and one of Morphine PCA unaccounted for.
Revoked 03/19/2013

Robertson, Christina Lea
Independence, MO
Registered Nurse 2007003743

On August 12, 2009, while on duty as an RN, Robertson appeared to be impaired and was directed to submit to a drug screen by her employer. According to the drug screen, Robertson tested positive for meperidine. A follow-up investigation revealed Robertson diverted meperidine for her own consumption. On April 21, 2009, while on duty as an RN, Robertson documented administering hydromorphone to a patient upon a physician’s verbal order. There was no physician’s order, and Robertson administered the controlled substance without a prescription. On April 23, 2009, Robertson was directed by her employer to submit to a drug screen. This drug screen tested positive for oxymorphone and propoxyphene. Robertson did not produce a prescription to possess either drug.
Revoked 03/19/2013

Becker, Jodi A.
Imperial, MO
Registered Nurse 142895

On April 17, 2009, at 7:00 a.m., Respondent withdrew two doses of Demerol. However, there was only one patient in the surgery wing at that time, and the patient was in surgery and unable to receive the Demerol. Neither dose of Demerol was documented as administered or wasted. On April 30, 2009, while on duty, Respondent attempted to start an intravenous (“IV”) administration twice on a patient, but did not chart such administration. On April 30, 2009, Respondent reported that she administered Demerol to a patient at 11:00 a.m. and 3:00 p.m. There is no charting of the 3:00 p.m. administration. On June 18, 2009, Respondent “hung a bag” of Vancomycin for a patient. The Vancomycin expired on June 10, 2009. On June 19, 2009, Respondent withdrew a dose of morphine at 9:20 a.m. that was not documented as administered or wasted. On June 25, 2009, Respondent administered Demerol to a patient complaining of pain, but failed to document this administration. On June 25, 2009, a patient under Respondent’s care complained of chest pains. Becker failed to notify a physician, the director of nursing, or anyone else.
Revoked 03/19/2013

Coy, Laura Michelle
Cameron, MO
Licensed Practical Nurse 2006030429

Respondent failed to contract with NTS by December 28, 2012. Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent did not attend the meeting or contact the Board to reschedule the meeting.
Revoked 03/19/2013

Owens, Jeannie Renee
Russellville, MO
Licensed Practical Nurse 2001025370

On March 14, 2007, while on duty, Owens stole \$53.00 from another nurse.
Revoked 03/19/2013

Barcum, Richard T.
Dorsey, IL
Registered Nurse 120355

A male patient was having a psychotic episode and was banging his head against a door. Respondent responded to the code grey and found the patient to be out of control, kicking, screaming, and beating the wall. Respondent ordered the others to take the patient down. Respondent grabbed the patient’s upper body while the security guards grabbed the patient’s legs to take him to the floor. Respondent then began to beat the patient in the head repeatedly. The patient was sedated, and the charge nurse instructed Respondent and the others to take the patient into the seclusion room. Two security guards dragged the patient by his feet to the sedation room in an effort to get the patient away from Respondent, who continued to kick the patient in the head, shoulders, and back as the patient was dragged down the hall. After the patient was placed in the bed and being restrained, Respondent got in the patient’s face. Using profanity, Respondent yelled at the patient and continued to beat him in the face. At one point, Respondent stuck his fingers in the patient’s eye sockets and raked his eyes. Both the patient’s face and Respondent’s hands were bloodied as a result of his assault on the patient.
Revoked 03/28/2013

Blakley, Milton L.
Savannah, MO
Registered Nurse 081720

On March 20, 2011, Respondent was assigned to care for eight residents with cognitive impairments. On March 20, 2011,

REVOCATION Continued....

Respondent spoke to resident in a “loud tone,” arguing with her about doing her breathing treatment because “it was light sensitive and if she didn’t take it right now, it would go bad.” A Certified Nurse Aid (CNA) on duty at the time observed Respondent’s interaction with resident and tried to “diffuse the situation” because the resident appeared to be “confused” by the interaction. The CNA observed Respondent in an interaction with a second resident. The CNA stated that she observed Respondent become “irate” with resident when the resident did not want his temperature to be taken. The CNA again tried to diffuse the situation and suggested they take the resident, L.B.’s, temperature later, but Respondent insisted it be taken then. Respondent held resident by the shoulders and stated to the resident “to behave or [he] would give him a shot to put him to sleep.” At around the same time, Respondent was making phone calls to residents’ family members. Respondent would report to the family members that he had been pushed or hit by a resident, then would tell the family member he forgave the patient. Respondent’s behavior in this manner lasted several weeks. Respondent was placed on an Employment Disqualification List (EDL) for a period of two (2) years.
Revoked 03/27/2013

Filla, Denise L.
Washington, MO
Licensed Practical Nurse 2004001920

On June 9, 2009, Filla administered two Darvocet pills to a patient when the physician’s order for that patient only called for a single Darvocet pill. Between June 8-19, 2009, Filla administered Ambien 5mg to a patient for twelve consecutive nights when the physician’s order for that patient called for only ten consecutive nights. Between June 8-19, 2009, Filla administered Ambien CR 6.25 mg to another patient daily. The physician’s order for that patient called for administration of this medication, but only on alternating days.
Revoked 03/19/2013

Harrison, Jessica Kay
Neosho, MO
Licensed Practical Nurse 2003030090

On September 9, 2009, Respondent was observed by a co-worker to be unconscious, slumped over in her chair, eyes closed, and foaming at the mouth. Respondent admitted that she diverted 18 tablets of hydrocodone from Patient. On October 14, 2010, Harrison was placed on the Department of Health and Senior Services’ (“DHSS”) Employment Disqualification List (“EDL”).
Revoked 03/27/2013

Mayoral, Karen P.
Columbia, MO
Registered Nurse 2005037769

Respondent was required to contract with the Board approved third-party administrator, currently National Toxicology Specialists, Inc. (NTS), to schedule random drug and alcohol screening within twenty (20) working days of the effective date of the Order. Respondent did not complete the contract process with NTS. Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent did not attend the meeting or contact the Board to reschedule the meeting. Respondent was required to undergo a thorough chemical dependency evaluation and have that evaluation submitted to the Board by November 7, 2012. The Board did not receive a chemical dependency evaluation. Respondent was required to obtain continuing education hours by December 26, 2012. The Board did not receive proof of any completed hours.
Revoked 03/19/2013

Bush, Julie Anne
Hannibal, MO
Licensed Practical Nurse 2008030271

Licensee’s name was placed on the employee disqualification list maintained by the Department of Health and Senior Services of the State of Missouri on May 26, 2010 for a period of two (2) years.
Revoked 03/26/2013

Fischer, Danielle Renee
Fort Scott, KS
Registered Nurse 2010026793

On February 7, 2013, Licensee notified the Board that she had been terminated from KNAP for noncompliance.
Revoked 03/26/2013

Johnston, Pamela K.
Shawnee Mission, KS
Registered Nurse 115628
Johnston pled nolo contendere and was convicted of attempted felony theft in the state of Kansas on May 12, 2006.
Revoked 03/19/2013

Hodges, Jennifer Ann
Saint Charles, MO
Registered Nurse 2011038633

Licensee failed to call NTS on fifteen (15) occasions, submitted a sample with a low creatinine level, and submitted a sample that tested positive for Lorazepam.
Revoked 03/26/2013

REVOCATION continued on page 19

Schenewerk, Lisa Gail
Fulton, MO
Licensed Practical Nurse 026560
On June 27, 2009, Respondent pre-poured and pre-signed for alprazolam, propoxy-N/APAP, and temazepam. These medications were later found by her supervisor and were not administered to the patients. Also, when she pre-signed, she pre-wrote the future times that the medications were to be administered on the patients' charts rather than the actual time she poured the medications.
Revoked 03/19/2013

Lugenbell, Stephanie A.
Joplin, MO
Registered Nurse 154011
In February 2007, Licensee diverted Propofol from her employer and injected herself with it.
Revoked 03/19/2013

SUSPENSION/PROBATION

Fortner, Amanda Rae
Dexter, MO
Registered Nurse 2007009501
On August 1, 2012, while on duty, Licensee was observed via video camera to be in the hospital pharmacy without permission and placing Tramadol from the pharmacy's stores into her pockets. Licensee was confronted by the next day, August 2, 2012, and after initially denying she had taken the Tramadol, then admitted she had taken the Tramadol from the pharmacy. At that time, the facility requested that Licensee take a drug test. On August 2, 2012, Licensee tested positive for Barbiturates and Benzodiazepines.
Suspension 04/30/2013 to 10/30/2013
Probation 10/31/2013 to 10/31/2018

Lahm, Candice Elizabeth
Kansas City, MO
Registered Nurse 2010034426
On March 12, 2012, Licensee accessed the RMC medical records for patient BM. Licensee used BM's patient information to write out a prescription for hydrocodone. Licensee forged the doctor's signature on the prescription.
Suspension 04/25/2013 to 10/25/2013
Probation 10/26/2013 to 10/26/2018

Yarbrough, Sherry L.
Naylor, MO
Registered Nurse 117004
From February 7, 2012, until February 13, 2013, Respondent failed to call in to NTS on ten (10) days.
Suspension 05/05/2013 to 05/11/2013
Probation 5/12/2013 to 12/28/2015

Troshynski, Larry J.
Kansas City, MO
Registered Nurse 154767
On August 23, 2012 Licensee's Kansas nursing license was suspended for one year from that date in a Consent Agreement and Final Order, of which eight months could be stayed provided Licensee complies with the terms of the Consent Agreement and Final Order. The Kansas Board of Nursing found that licensee had violated the Kansas Nursing Practice Act in several ways, including but not limited to, removing medications while working as a nurse that were later unaccounted for and various other narcotic discrepancies while working as a nurse. The Kansas Board also found that licensee had been disciplined by the Nursing Boards of the states of Iowa and Nebraska for similar offenses. Licensee also admitted in the Kansas Board of Nursing Consent Agreement and Final Order that although he was currently in the Kansas Nurse Assistance Program (KNAP) at the time, he tested positive for Fentanyl, on one occasion, and in addition had missed a scheduled drug screen which he was required to submit to as part of being in the Kansas Nurse Assistance Program.
Suspension 03/01/2013 to 03/01/2015
Probation 3/2/2015 to 3/2/2020

VOLUNTARY SURRENDER

Sargent, Saundra D.
Carthage, MO
Registered Nurse 142521
Effective April 6, 2013, License was to be Suspended for 6 months followed by 5 years probation. On May 20, 2013, Licensee Voluntarily Surrendered her license.
On August 23, 2012, Licensee withdrew some medications in syringes for a scheduled procedure. The procedure was canceled and Licensee asked a coworker, CB, to help her waste the medications. CB did not observe the withdrawal of the medications so refused to observe the wasting. CB called a supervisor to find out how to proceed. Licensee and CB were informed to go to the pharmacy to verify the medications and waste the medications there. Before heading to the pharmacy, CB observed Licensee with a needle and syringe drawing something out of a vial. CB confronted Licensee about what was in the vial and Licensee hid the vial in her pocket. CB then called a supervisor to handle the situation. When the supervisor arrived, Licensee removed the vial from her pocket and her supervisor saw that it contained Demerol. Licensee admitted that she was going to take the medication for her personal consumption. Licensee was requested to submit to a for cause urine drug screening test given by her employer. The urine sample tested positive for Oxazepam, Temazepam, and

VOLUNTARY SURRENDER Continued....

Clonazepam. Licensee did not have a lawful reason or prescription to possess Oxazepam, Temazepam, and Clonazepam.
Voluntary Surrender 05/20/2013

Vahlkamp, Suzan
Quincy, IL
Licensed Practical Nurse 046090
On April 27, 2012, Licensee filed an online renewal application to renew her licensed practical nurse license and misrepresented her prior license status in the information she provided to the Board.
Voluntary Surrender 05/31/2013

Young, Elain Kay
Callao, MO
Licensed Practical Nurse 022397
On March 19, 2012, Licensee was convicted of knowingly conspiring to commit the crime of murder for hire by using the US mail and other facilities resulting in death and used or caused another to use the mail with the intent that murder be committed.
Voluntary Surrender 05/09/2013

Jennings, Tammy Lynn
Harrisonville, MO
Registered Nurse 2007003052
On October 8, 2011, patients VU, EK, and NH reported thefts of cash and credit cards while being treated at a facility. Licensee was the nurse caring for patients VU, EK, and NH when the items were discovered missing. On October 8, 2011, Licensee entered the break room and tripped over a chair and almost fell. Other staff members in the break room reported that Licensee appeared intoxicated. Licensee was requested to submit a sample for a for-cause drug screen. Licensee refused to submit a sample for drug testing and resigned. On February 4, 2013, Licensee pled guilty to Burglary second degree and to Stealing. On February 4, 2013, Licensee pled guilty to Manufacturing a Controlled Substance, Possession of a Controlled Substance, and Possession of Chemicals with the Intent to Manufacture a Controlled Substance. On February 4, 2013, Licensee pled guilty to Stealing for taking a credit card from EK, Stealing for taking a credit card from NH, Stealing for taking a credit card from NH, and Stealing for taking U.S. currency from VU.
Voluntary Surrender 05/10/2013

Rice, Heather R.
Raymore, MO
Registered Nurse 151928
On May 9, 2013, Licensee voluntarily surrendered her Missouri nursing license.
Voluntary Surrender 05/09/2013

Taylor, Erin Morgan
Adrian, MO
Licensed Practical Nurse 2004029082
On May 9, 2012, Respondent provided a pre-employment drug screen. The drug screen tested positive for marijuana. Licensee admitted that she smoked marijuana.
Voluntary Surrender 05/21/2013

Warren, Shannon
Caruthersville, MO
Registered Nurse 138963
Licensee voluntarily surrendered her nursing license on 4/24/2013.
Voluntary Surrender 04/24/2013

Estopare, Jeffrey E.
Shawnee Mission, KS
Registered Nurse 2010005398
The Kansas State Board of Nursing issued a Default Order to Revoke the nursing license of Licensee upon grounds for which suspension or revocation is authorized in Missouri.
Voluntary Surrender 05/09/2013

Sanders, Andrea Ruth
Jefferson City, MO
Registered Nurse 2008007343
Licensee voluntarily surrendered her nursing license on April 18, 2013.
Voluntary Surrender 04/18/2013

Rose, Karen Renee
Saint Peters, MO
Licensed Practical Nurse 2000167161
Licensee voluntarily surrendered her license on March 4, 2013.
Voluntary Surrender 03/04/2013

Howard, Shonda Renee
Zalma, MO
Licensed Practical Nurse 2004024361
In November and December of 2011, Licensee diverted Percocet from her employer for her personal use. On May 22, 2012, Licensee pled guilty to the class A misdemeanor of Stealing. As of November 13, 2012, Licensee's name has been permanently added to the employee disqualification list maintained by the Department of Health and Senior Services for the State of Missouri.
Voluntary Surrender 04/15/2013

Fraction-Jones, Patricia A.
Saint Louis, MO
Licensed Practical Nurse 055699
On February 25, 2012, Licensee used language that constituted verbal abuse of a patient.
Voluntary Surrender 04/10/2013

VOLUNTARY SURRENDER Continued....

Larsson, Robin Luanne
Arnold, MO
Registered Nurse 2005038786
In June 2012, Licensee diverted hydrocodone from her employer for her personal use.
Voluntary Surrender 04/25/2013

Winefeldt, Gail N.
Lockwood, MO
Licensed Practical Nurse 048746
Licensee voluntarily surrendered her license on April 3, 2013.
Voluntary Surrender 04/03/2013

Matchell, Ann L.
Eureka, MO
Registered Nurse 107116
On January 14, 2005, Licensee pled guilty 'Possession of Any Methamphetamine Precursor Drug with Intent to Manufacture.' On August 19, 2008, Licensee was found guilty of 'Possession of a Controlled Substance'. Since the date of her guilty pleas in 2005 and 2008, Licensee has renewed her license on or about June 8, 2005, March 26, 2007, April 22, 2009, and April 26, 2011. At no time did Licensee inform the Board of the findings of guilt. Each renewal form specifically asks if Licensee has been "convicted, adjudged guilty by a court, pled guilty or pled nolo contendere to any crime, whether or not sentence was imposed (excluding traffic violations)" and requests Licensee to provide certified court documents. Voluntary Surrender. 03/12/2013

Turner, Deborah Lynn
Kennett, MO
Licensed Practical Nurse 2000168027
Licensee voluntarily surrendered her Missouri nursing license on May 28, 2013.
Voluntary Surrender 05/28/2013

Vorhies, Iris Y.
Lees Summit, MO
Registered Nurse 2007018275
Licensee admitted to taking five (5) tablets of Ambien out of the Accudose for her personal consumption.
Voluntary Surrender 03/12/2013

Knourek, Valerie Jean
Mission, KS
Licensed Practical Nurse 2002008247
During the period of approximately June 17, 2012 through July 12, 2012, Licensee committed several different medication and documentation errors. Licensee falsified documents by documenting on a Medical Administration Record (MAR) that medications were given, but did not document on the appropriate narcotics sheet used for tracking medications, or give, at least five doses of the medication of Ativan to a resident during that period. The resident in question had a physician's order for .25 CC Ativan three times daily. In particular, Licensee on June 17, 2012 documented removal of Ativan from the Manor's supply at 2200 but did not document the administration or waste of the Ativan. Also on that date, licensee documented removal of a second dose of Ativan at 0330 when the next dose was not due until 0600. On July 7, 2012, licensee did not document or give an Ativan dose at 2200. On July 8, 2012, licensee did not document or give an Ativan dose at 0600. On July 11, 2012 licensee did not document or give an Ativan dose at 2200. On July 12, 2012, licensee did not document or give an Ativan dose at 0600.
Voluntary Surrender 03/01/2013



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Professional Boundaries: When Does the Nurse-Patient Relationship End?

Denise Benbow, MSN, RN

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of Nursing

Note: This article references the Texas Nursing Practice Act. Missouri's laws are very similar.

A home health nurse established a nurse-patient relationship while providing care through a home health agency. After the nurse stopped working for the agency, she continued to visit the patient and accepted gifts from him. A complaint was filed with the board of nursing, and an investigation found that the nurse violated provisions of the Nursing Practice Act of 2011, including those regarding professional behavior and boundary violations. The nurse contested the finding, and the case went to an administrative law judge, who found that the nurse had violated professional boundaries. This article reviews this case in depth along with the legal and ethical implications for the practicing nurse.

While working for a home health company, a female registered nurse cared for an elderly male patient for several months. After the nurse left the home health agency, she continued to visit the patient. During those visits, she engaged in discussions about her personal life. She even brought her children to meet the patient. Over the subsequent months, the elderly man started giving substantial gifts to the nurse and her children. During at least one of her visits, she wore her nursing scrubs, causing confusion for family members who wondered why their father had two home health nurses from two different agencies. A complaint was then submitted to the Texas Board of Nursing (BON).

Patients expect a nurse to act in their best interest, respect their dignity, and avoid personal gain at their expense. Nurses have a duty to establish and maintain professional boundaries of the nurse-patient relationship. Understandably, some home health patients become attached to their nurses and may want to maintain contact after a nurse changes employers. However, such continued contact raises questions about the boundaries of the nurse-patient relationship. Does the end of the nurse's employment define the end of the nurse-patient relationship? Or are other factors at play? To answer these questions, the Texas BON focuses on the nature of the relationship between the nurse and the patient, not simply on the nurse's employment status. Employment as a nurse is not a requirement for a nurse to practice nursing; likewise, there is not a definition of when the nurse-patient relationship ends. The Texas Nursing Practice Act (2011) defines professional (registered) nursing practice as founded on the specialized nursing knowledge acquired through nursing education and application of that knowledge. The nature of the relationship and nurse-patient interactions play a role in determining any ongoing responsibilities of the nurse.

This article reviews a case in which a nurse cared for a patient in the patient's home, terminated her employment, but continued to see the patient. There was no break in time between the end of the nurse-patient relationship and the beginning of another type of relationship. During these subsequent visits, the nurse accepted monetary gifts, gifts for her family, and meals. A complaint was filed with the BON. The investigation found that the nurse violated provisions of the Nursing Practice Act (2011), including those regarding professional behavior and boundary violations. The nurse did not agree with the finding, resulting in a contested case hearing before an administrative law judge (ALJ). The hearing is reviewed here along with the legal and ethical implications for the practicing nurse.

Defining Professional Boundaries

The National Council of State Boards of Nursing (NCSBN, 2011) defines professional boundaries as "the spaces between the nurse's power and the patient's vulnerability." (See Figure 1.) The Texas Administrative Code defines professional boundaries as "the appropriate limits which should be established by the nurse in the nurse/client relationship due to the nurse's power and the patient's vulnerability." Further, the Code refers to the provision of nursing services within the limits of the nurse-client relationship, which promote the client's dignity, independence, and best interests and deter inappropriate involvement in the client's personal relationships and personal gain at the client's expense (22 Tex. Admin. Code §217.1 (29); see Table 1). The commonality between these two definitions establishes the nurse as the protector of the power differential between the patient and the nurse.

The BON Investigation

When a complaint comes into the BON, it is reviewed, assigned a priority, and assigned to an investigator. The nurse receives written notice regarding the facts or conduct that is alleged and could lead to disciplinary licensure action (22 Tex. Admin. Code §213.14 (b)). The nurse is provided an opportunity to respond in writing and to present her view on the events in question (22 Tex. Admin. Code §213.14 (b) & (c)). The investigator collects evidence. The evidence may or may not substantiate a violation of the Nursing Practice Act of 2011 or Board Rules. A failure to meet the minimum standards of nursing practice or engaging in unprofessional conduct may result in disciplinary action (Nursing Practice Act, 2011; see Table 1). Both the minimum standards rule and the unprofessional conduct rule address professional boundaries and are based on the Texas definition of professional boundaries (22 Tex. Admin. Code §§217.1 (29); 217.11 (1) (J); and 217.12(6) (D); see Table 1).

After receiving the complaint about the nurse's behavior, the Texas BON investigated the case. At the conclusion of the investigation, the BON notified the nurse that her conduct required discipline because it violated provisions of the Nursing Practice Act

(2011), including those regarding professional behavior and boundary violations. The nurse's behavior was clearly a violation: She accepted gifts from a former patient. However, the nurse contested the BON's decision contending that she did not violate the nurse-patient boundaries because she was no longer an employee of the home health company that provided care for the patient. Thus, the issue of the nurse-patient relationship became central and the case went before an ALJ for a hearing.

Administrative Hearing

When a contested case is heard by an ALJ, the BON must prove there was a violation. The ALJ considers the testimony and evidence to determine if the BON has proved the case by preponderance of the evidence, or it is more likely there was a violation than that there was not a violation. A number of witnesses testified at the hearing, including the adult children of the patient, several nurses, social workers, and the nurse defendant. By the time of the hearing, the patient had died, but he too was heard via a deposition taken before his death.

Patient and His Family

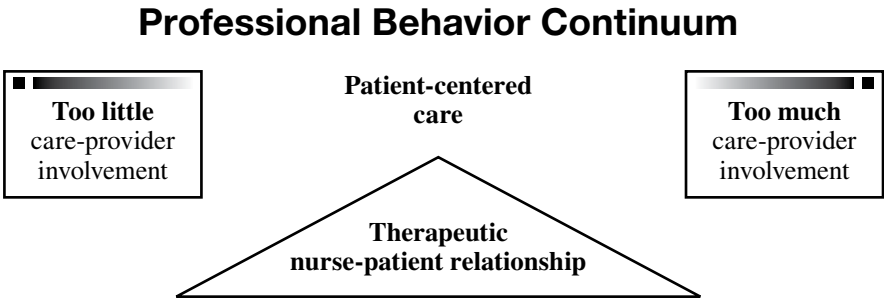
The elderly patient's deposition revealed he did not understand when the nurse stopped working for the home health agency. All the dates he referenced in his deposition were in the months after the nurse left the agency.

The adult children of the patient testified about the patient's financial status, the number and types of gifts he gave the nurse, and the financial impact on the patient, who was no longer able to earn an income. They also testified that the nurse wore her nursing uniform and name tag when visiting the patient.

Nurses

The home health nurse assigned to care for the patient in the months after the defendant left the agency testified that she was concerned because the patient said his former nurse continued to visit. Moreover, the patient told his new nurse about the gifts

Figure 1



The professional behavior continuum provides a frame of reference to help nurses evaluate their professional interactions with patients. The patient is in the center of the continuum, where patient and nurse interactions occur in a therapeutic nurse-patient relationship. Examples of too much involvement with the patient include boundary crossings and violations.

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he gave his former nurse. According to her testimony, the new nurse was concerned about the patient's financial status and the financial resources going to his former nurse. As a representative of the home health care agency, this nurse also testified about agency policies on gift-giving and about the vulnerability of this patient population and this specific patient.

A nurse with a background in home health testified about the essential role of the nurse in establishing professional boundaries, including financial boundaries related to gifts. She noted that the nurse is always responsible for setting professional boundaries and has access to information in the nurse-patient relationship that might influence future interactions.

The Nurse Defendant

The defendant's testimony included information about the declining health of the patient, her relationship with the patient, details about the gifts she received, and the education she received about professional boundaries. The nurse acknowledged that the patient had a terminal condition and that his condition deteriorated over the time she cared for him as a nurse and their subsequent interactions. However, she maintained that her duty to the patient ended when she left the agency and that the patient understood that she was no longer his nurse.

The nurse testified that while she acted as the patient's nurse, he asked questions about her family situation and personal finances, but she did not provide more than "yes" or "no" answers to these questions. However, when the nurse was no longer employed as the patient's nurse, she provided him with information about her personal life and brought her children to meet him, and he gave substantial gifts to her and her children over the subsequent months.

When asked about the education she received regarding professional boundaries, the nurse testified that she received education in nursing school and through in-service programs on professional boundaries but, she claimed, the emphasis of the education and training was on sexual boundaries.

Proposal for Decision and Order of the BON

Table 1	<div>Professional Boundaries: Texas Board of Nursing Law</div> <div>The Texas Nursing Practice Act and the Administrative Code define professional boundaries and specify disciplinary actions for violations.</div> <div>Nursing Practice Act (Texas Occupations Code, Chapter 301)</div> <div>§301.452, Grounds for Disciplinary Action</div> <div>(b) A person is subject to denial of a license or to disciplinary action under this sub chapter for:</div> <div>(10) unprofessional or dishonorable conduct that, in the Board’s opinion, is likely to deceive, defraud, or injure a patient or the public;</div> <div>(13) failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board’s opinion, exposes a patient or other person unnecessarily to risk of harm.</div> <div>Texas Administrative Code</div> <div>§217.1, Definitions</div> <div>(29) Professional boundaries. The appropriate limits which should be established by the nurse in the nurse/client relationship due to the nurse’s power and the patient’s vulnerability. Refers to the provision of nursing services within the limits of the nurse/client relationship which promote the client’s dignity, independence and best interests and refrain from inappropriate involvement in the client’s personal relationships and/or the obtainment of the nurse’s personal gain at the client’s expense.</div> <div>§213.27, Good Professional Character</div> <div>(b) Factors to be used in evaluating good professional character in eligibility and disciplinary matters are:</div> <div>(2) A person who seeks to obtain or retain a license to practice professional or vocational nursing shall provide evidence of good professional character which, in the judgment of the Board, is sufficient to insure that the individual can consistently act in the best interest of patients/clients and the public in any practice setting. Such evidence shall establish that the person:</div> <div>(F) is able to recognize and honor the interpersonal boundaries appropriate to any therapeutic relationship or health care setting</div> <div>§217.11, Standards of Nursing Practice</div> <div>(1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:</div> <div>(J) Know, recognize, and maintain professional boundaries of the nurse-client relationship</div> <div>§217.12, Unprofessional Conduct</div> <div>(6) Misconduct—actions or conduct that include[s], but [is] not limited to:</div> <div>(D) Violating professional boundaries of the nurse/client relationship including but not limited to physical, sexual, emotional or financial exploitation of the client or the client’s significant other(s)</div>
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After the case concluded, the ALJ issued a proposal for decision (PFD) that was presented to the BON for ratification and resulted in an order of the BON. The PFD included an analysis, recommendations, findings of fact, and conclusions of law.

An essential question in this case was whether a nurse-patient relationship exists after the nurse is no longer employed to care for the patient. There was no disagreement regarding the beginning of the nurse-patient relationship. In this case, the ALJ found that the nurse-patient relationship continued beyond the nurse’s employment as a home health nurse and that the BON was authorized to attach discipline to the nurse’s license.

The finding was based on the following:

- The BON definition of professional boundaries identifies a benefit to the nurse as a boundary violation (22 Tex. Admin. Code §217.1 (29)).
- BON rules require nurses to meet the minimum standards of practice by maintaining professional boundaries in the nurse-patient relationship (22 Tex. Admin. Code §217.11 (1)(J)).
- If there are aspects of the nurse-patient relationship that could continue indefinitely, the nurse has an indefinite responsibility to maintain professional boundaries.

The BON reviewed the PFD and determined the level of sanction to impose on the nurse’s license. A range of disciplinary sanction levels and a variety of specific conditions can be imposed. In this case, the disciplinary sanction of a warning was applied. The sanctions included educational course work and a monetary fine.

Providing Guidance for Nurses

Nursing education programs provide a critical foundation for nursing practice and an understanding of the legal and ethical requirements of the nursing profession, including all aspects of professional boundaries. This nurse did not see any potential issues with terminating employment at the home health company and then continuing to see the patient, even though the roots of the relationship were firmly established in the nurse-patient encounters. The patient had ongoing health care needs with declining physical and financial abilities; thus, he may have had a motivation to keep the nurse in a relationship for his benefit, even if that meant he had to sacrifice money to entice her to continue to see him. Further confusion for the patient and family was caused by the nurse visiting the patient’s home in her nursing uniform.

Nurses have a responsibility to set clear professional boundaries, to abide by those professional boundaries, and to refrain from violating those professional boundaries. Certain behaviors are red flags that should alert nurses to examine their patient relationships for potential boundary crossings or violations (NCSBN, 2011):

- Excessive self-disclosure: Discussing personal problems or aspects of his or her intimate life with the patient
- Secretive, defensive behavior: Keeping secrets with the patient or becoming defensive when questioned about interactions with the patient
- Excessive patient attention: Spending an inappropriate amount of time with the patient, visiting the patient when off duty, or trading assignments to care for the patient
- Non-therapeutic relationship: Believing only he or she understands and can meet the patient’s needs or allowing the patient to pay special attention, for example, by giving gifts

Conclusion

The central question in this case was when does a nurse’s duty to a patient end? When a relationship is rooted in the nurse-patient relationship, it can be difficult for the patient to determine when the relationship ends and to transition to some other form of a relationship. The burden is on the nurse to identify and maintain professional boundaries in the best interests of the patient.

Some aspects of the nurse-patient relationship, such as confidentiality of patient-protected information, never end. In this case, the nurse violated the professional boundary even though she was no longer the patient’s nurse.

References

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Denise Benbow, MSN, RN, is Nursing Consultant for Practice at the Texas Board of Nursing.

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